

UNDERSTANDING THE LIVES OF BIPOLAR WOMEN WITH
POST-SECONDARY SCHOOL EXPERIENCE

by

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DISSERTATION ABSTRACT

Understanding the Lives of Bipolar Women with Post-Secondary School Experience

Problem: Bipolar disorder affects 2.6% of the population over age 18 and often presents for the first time during the college years (Lejeune, 2011). Students at this age already face challenges in adapting to a new lifestyle, and those with a mental illness face additional challenges amidst an environment that doesn't necessarily provide stability for successful management of bipolar disorder. There is a dearth in the literature investigating personal life histories of bipolar adults that identify common themes in early years regarding bipolar disorder onset and later years in coping mechanisms during post-secondary school.

Procedures: This qualitative phenomenological research study examined the lived experiences of six women with bipolar disorder who attended post-secondary school. This study was motivated by the research questions: (1) What are the experiences of one living with bipolar disorder? (2) What are successful coping strategies while navigating a post-secondary degree? Understanding and describing the essence of a lived phenomenon (Van Manen, 1990) was the foundation of my work. Narrative interviews (Seidman, 2006) were used to collect data to allow the participants to tell their stories and share the experiences of living with bipolar disorder.

Findings: Emergent themes included home/family life, the onset of bipolar disorder, school involvement/achievement, and coping strategies, which produced the following findings: none of the participants shared their mental instability during post-secondary school with any educational professional, bipolar disorder for females is at its worst during hormonal cycles, childhood abuse is connected to adult onset bipolar disorder, participants who experienced childhood abuse later abused substances, low self-esteem and feelings of worthlessness were factors amongst participants, all participants were high-achievers as youngsters, coping strategies included pharmaceutical intervention, exercise, eating healthy foods, getting adequate sleep, having a strong support system, and cognitive reshaping through therapeutic counseling intervention.

Conclusions: Many people with bipolar disorder lead productive, successful lives. Ongoing research in this field, along with support from family, friends, and educators is essential in helping these individuals find balance, happiness, connection to others, and successful coping strategies during post-secondary school and in life in general.

Recommendations: Educating school personnel on bipolar disorder would lead to greater mental illness awareness, help identify at-risk students, and provide possible accommodations. The link between childhood abuse and bipolar disorder needs to be further explored. The fact that high-achieving youngsters are four times at greater risk for later bipolar disorder than students with average school performance (MacCabe et al., 2010) is worthy of further examination. Teachers and administrators should pay close attention to high-achieving youngsters who exhibit signs of low self-esteem and perfectionism. The link between bipolar disorder and the female hormone cycle should be further examined in order to provide support to women, especially after childbirth.

DEDICATION

For my mother, Marna Jayne Goodson,
who taught me how to be a strong and independent woman.

'Beauty is truth, truth beauty,' - that is all ye know on earth, and all ye need to know.

John Keats

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Chapter 1

INTRODUCTION

Mental Health Disorders

In a given year, one in four adults, approximately 57.7 million Americans experience a mental health disorder. These disorders include schizophrenia, anxiety disorders, obsessive-compulsive disorders, post-traumatic stress disorders, and mood disorders such as major depression and bipolar disorder, formerly known as manic-depression. In the United States, the annual economic cost of mental illness is estimated to be \$79 billion (National Institute of Mental Health, [NIMH], 2012). The statistics are grim for individuals living with serious mental illnesses. Such individuals are at greater risk of having chronic medical conditions and substance abuse issues (NIMH, 2012). On average, adults living with serious mental illness die 25 years earlier than other Americans (NIMH, 2012). Suicide is the eleventh-leading cause of adult deaths in the United States. Of those who die by suicide, more than 90 percent have a diagnosable mental disorder (NIMH, 2012).

Bipolar Disorder

Bipolar disorder affects 2.6% of the population over age 18 (Lejeune, 2011) and often presents for the first time during the college years. Students at this age already face challenges in adapting to a new lifestyle, and those with a mental illness face additional challenges amidst an environment that doesn't necessarily provide stability for successful management of bipolar disorder (Lejeune, 2011). "To further complicate this, their environment has many of the kinds of stimulation that can exacerbate mania: Students

frequently race against deadlines, stay up late for academic or social reasons, and use alcohol and drugs.” (Lejeune, 2011, p. 666)

Living with bipolar disorder is an ongoing struggle. It can take years to come to terms with the diagnosis and can be very difficult to understand. Mood disorders affect the whole person. Within the whole person there lies a battle with oneself, combined with feelings of shame and guilt (Inder et al., 2008; Jönsson, Wijk, Skärsäter & Danielson, 2008; Proudfoot et al., 2009; Rusner, Carlsson, Brunt, & Nystrom, 2009).

Bipolar disorder is a diagnosable illness, like any other medical condition. Although its presence throughout history has been documented, it wasn't until the late nineteenth century when German psychiatrist, Emil Kraepelin, defined affective disorders, which he constructed from the work of a small group of nineteenth century European psychiatrists (Goodwin & Jamison, 1990). Kraepelin (1921) categorized psychoses into two groups: manic-depressive illness and schizophrenia. His work became the framework for later progress in defining affective disorders. Kraepelin (1921) states:

...notwithstanding manifold external differences, certain *common fundamental features* yet recur in all the morbid states mentioned. Along with changing symptoms, which may appear temporarily or may be completely absent, we meet in all forms of manic-depressive insanity a quite definite, narrow group of disorders, though certainly of varied character and composition. Without any one of them being absolutely characteristic of the malady, still in association they impress a uniform stamp on all the multiform clinical states. (p.2)

In other words, to understand the complexity of the disease and to be able to make an accurate diagnosis, clinicians must refer to Kraepelin's *common fundamental features*

(Goodwin & Jamison, 1990). From these features emerged characteristics, coping skills, as well as traits and definitions commonly used in the current Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V).

School Achievement and Risk of Adult Onset Bipolar Disorder

A 2010 quantitative research study (MacCabe et al., 2010) investigated possible associations between school achievement and later adult onset bipolar disorder. The study examined 713,596 individuals who completed compulsory schooling in Sweden from 1988 to 1997 to test the associations between scholastic achievement at age 16 and hospital admission for psychosis between the ages of 17-31 (MacCabe et al., 2010). The results indicated that individuals with excellent school performance and high academic grades were four times at greater risk for later bipolar disorder than individuals with average school performance and average academic grades (MacCabe et al., 2010). This supports previous research that there is a link between human accomplishment and bipolar disorder (Goodwin & Jamison, 1990). This research study (MacCabe et al., 2010) also examined the common characteristics between creativity and school performance, although this link is poorly understood. Students with high academic grades in subjects which encompass the concept of creativity, such as art, music, and creative writing, have “particularly strong associations with risk for bipolar disorder” (MacCabe et al., 2010, p.113). This provides support for biological findings from researchers such as Goodwin & Jamison (1990) that there are direct associations between musical and linguistic creativity and bipolar disorder (MacCabe et al., 2010).

The links between intelligence, creativity, high achievement in school, and later onset of bipolar disorder are worthy of further study and understanding. This could lead

to intervention from school personnel for identification of students at risk for bipolar disorder, and greater awareness of risk factors for the disorder. Goodwin & Jamison (1990) conclude that there is an urgent need for population-based studies on bipolar disorder. It is my hope that my research study on the post-secondary school experiences of individuals diagnosed with bipolar disorder will lead to future studies and a greater understanding amongst the educational community for academic and emotional support of students with bipolar disorder.

Management of Mood Disorders

A 2010 qualitative study of 33 people on successful self-management of chronic mental illness, which focused particularly on bipolar disorder, found that there are six strategies which have proven to be successful for high-functioning adults living with bipolar disorder. The strategies are: (a) sleep, rest, diet and exercise, (b) ongoing monitoring, (c) reflective and meditative practices, (d) understanding bipolar disorder and educating others, (e) connecting with others, and (f) enacting a plan (Murray et al., 2011). This important study states that while there are a number of quantitative studies on the subject, there are only a scant number of qualitative studies which examine the strategies of adults living with bipolar disorder who are self-managing their illnesses and staying well (Murray et al., 2011).

As stated earlier, a common trait in people with mood disorders is creativity (Andreasen, 1987; Jamison, 1993; Ramey & Weisberg, 2004). This outlet is possibly an effective coping mechanism for many individuals with mood disorders. Another possible coping mechanism is in staying busy, resulting in over-achievement and goal attainment (Johnson et al., 2000; Eisner, Johnson, & Carter, 2008; Knowles et al., 2007). There is

ample research (Michalak, Yatham, Kolesar, & Lam, 2006; Jamison, 1993; Johnson et al., 2000; Eisner et al., 2008; Knowles et al., 2007; Proudfoot et al., 2009; Rusner et al., 2009; McManamy, 2006) on people who live with mood disorders, and whom successfully use strategies such as getting enough sleep and exercise, meditation, medication, cognitive and behavioral therapy, and family and community support. There is, however, a dearth in the literature that examines successful coping and self-management strategies of mood disorders while navigating a post-secondary school experience. It is my goal in this qualitative study to hear individual life stories and post-secondary school experiences of adults clinically diagnosed with bipolar disorder specifically, and to identify common coping strategies and self-management techniques.

Purpose of the Study

Talking to those affected with bipolar disorder is the first step on the road to better understanding mood disorders (McManamy, 2006). To fully grasp what a person feels and experiences, phenomenological interviews provide the best opportunity for rich, descriptions in a qualitative study, allowing the researcher and reader to feel the experiences of the participant (Ponterotto, 2006). The purpose of this phenomenological qualitative study is to understand the post-secondary school “lived experiences” (Van Manen, 1990) of women diagnosed with bipolar disorder. It is important to understand these phenomena so that this often misunderstood disorder and its accompanying coping strategies can be utilized and further understood within the context of education.

Rationale and Significance

Examining women with bipolar disorder can lead to a greater understanding of such individuals, as well as shed light on successful coping strategies they used to

manage their illness while navigating through post-secondary school. By sharing stories of those affected with bipolar disorder, perhaps the stigma often attached to these individuals can be lifted, and the emerging coping strategies can be identified as useful tools by the individual, educators, family members and friends, as well as clinicians and society at large.

I approached my research with a constructivist worldview. Constructivists “hold assumptions that individuals seek understanding of the world in which they live and work” (Creswell, 2008, p. 8). Researchers with a constructivist lens view their participants through historical and cultural contexts, as well as through their own lived experiences in order to better understand and interpret meaning (Creswell, 2008). The theoretical context from which I approached my research is through a narrative research context so as to allow the participant to simply tell her story and share her experience of living (Creswell, 2007) with bipolar disorder, much like in recent research studies on living with the illness (Proudfoot et al., 2009; Rusner et al., 2009). Hearing the participant’s story allowed me to further understand his or her life experience.

Many people with bipolar disorder lead productive, successful lives. Ongoing research on post-secondary school experiences of adults with bipolar disorder, along with the appropriate levels of support from family, teachers, school administrators and staff, friends, and the medical communities, is essential in helping these individuals find stability, balance, happiness, and success in post-secondary school. This study can provide for greater understanding of this phenomenon, and possibly assist others who are diagnosed with bipolar disorder to successfully navigate through a post-secondary degree.

Researcher Positionality

As a licensed educational leader and member of the National Alliance on Mental Illness [NAMI], I have experience with this topic in the classroom, as a mental health advocate, and mental health consumer. I have observed individuals afflicted with mood disorders that never seem to overcome the obstacles associated with the disorder. These individuals seem to slip through the cracks, never having found stability in their lives (Goodwin & Jamison, 1990). Yet others with mood disorders, with the support of family, friends, community, and personal strength, not only find stability, but they thrive, despite their diagnosis (Goodwin & Jamison, 1990). I want to understand why. After reading research studies on the lived experiences of adults with bipolar disorder, I interviewed adults with the same illness who have post-secondary school experience. This narrative interview qualitative approach allowed me to “hear silenced voices” (Creswell, 2007, p.40) from a community of people who are often afraid to tell their stories because of the social stigma, and in turn are often misunderstood.

Research Questions

I explored the life trajectories, post-secondary school experiences and coping strategies of women clinically diagnosed with manic-depression, or bipolar disorder. Research questions in this type of study should be “highly open-ended, allowing for multiple avenues of research to develop” (Butin, 2010, p. 53). Creswell (2007) recommends the use of a grand tour question, which is the overarching question, as an umbrella that is guided by underlying questions to support the grand tour question. This dissertation study addressed the following grand tour research question (Creswell, 2007):

What are the life trajectories of women with bipolar disorder that preceded their post-secondary school experiences?

Definition of Terms

- *Bipolar disorder*, also called manic-depressive disorder, is associated with mood swings that range from the lows of depression to the highs of mania. When an individual becomes depressed, feelings of sadness or hopelessness occur with a loss of interest or pleasure in most activities. When the mood shifts in the other direction, there may be euphoria and fullness of energy. Mood shifts may occur only a few times a year, or as often as several times a day. In some cases, bipolar disorder causes symptoms of depression and mania at the same time (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V), 2013).
- *Coping strategies* are behavioral tools which may be used by individuals to offset or overcome adversity, disadvantage, or disability without correcting or eliminating the underlying condition.
- *Depression*, also called major depression, major depressive disorder and clinical depression, is a medical illness that causes a persistent feeling of sadness and loss of interest. Depression can lead to a variety of emotional and physical problems. More than just a bout of the blues, depression isn't a weakness, nor is it something a person can simply "snap out" of. Depression is a chronic illness that usually requires long-term treatment

(American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V), 2013).

- *Mania* is a state of excessive or abnormally high arousal, mood and energy levels. Mania is often associated with bipolar disorder. People with bipolar disorder experience cycling periods of mania with alternating periods of major depression. The symptoms and severity of mania can vary. Some experience only mild symptoms known as hypomania, in which they tend to need less sleep, have elevated energy levels and show an increased metabolism. In more severe cases of mania, people may sometimes display psychotic symptoms that can include delusions and hallucinations (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V), 2013).
- *Mood Disorder* is defined as a group of mental disorders marked by depression or mania. They are characterized by periods of depression, which may alternate, with periods of elevated mood. While many people go through sad or happy moods from time to time, people with mood disorders reach extreme highs and devastating lows that significantly impair their functioning. Mood disorders are outside the bounds of normal fluctuations from sadness to joy. Duration is also a factor. While it is possible to become excited or elated at certain moments, people with a mood disorder can sustain that feeling for several days severely impacting their ability to relate and function (American Psychiatric Association,

Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V), 2013).

Living with bipolar disorder can present many challenges at home, in school and in life in general. With support from family, educators, and medical professionals, those afflicted with the illness can find success and fulfillment in life.

Chapter 2

LITERATURE REVIEW

There is a plethora of literature on living with bipolar disorder. While this literature identifies common characteristics and challenges of living with this mental illness (Proudfoot et al., 2009; Rusner et al., 2009), there is not a great deal of research that identifies successful coping strategies and self-management of bipolar disorder during post-secondary school. Focusing on research which shares the participant's story, in the context of successful self-management of bipolar disorder throughout post-secondary school, will allow me to further understand the life experience itself, in the areas regarding social stigma, diagnosis, creativity as an outlet, self esteem, the existence of childhood abuse and gender differences.

Defining Mood Disorders

The notion of the existence of acute swings in personality, often referred to as genius and madness, can be found throughout history and literature dating back to pre-Grecian mythology (Jamison, 1993). Dionysus, the son of the god, Zeus, and the mortal, Semele, was affected with experiences shifting from intense euphoria to intense terror. Dionysus has come to symbolize polar extremes on continuums of good and evil, god and mortal, and even male and female. Dionysus is the epitome of the paradox. This dichotomous theme of genius and madness has frequently surfaced throughout history, from during the time of Plato and Socrates in their references to "divine madness" and melancholic/artistic temperaments (Jamison, 1993); to again later in the writings of philosopher Nietzsche, who writes "At the very climax of joy there sounds a cry of horror or a yearning lamentation for an irretrievable loss" (as cited in Schotten, 2008, p. 90).

This notion of polar shifts or extremes in the human mind evolved into the realm of mental illness and psychosis in the late nineteenth and early twentieth centuries, as seen in the psychological, scholarly writings of William James and Emil Kraepelin (Jamison, 1993) about manic-depression, which is today known as bipolar disorder.

Bipolar disorder and depression are diagnosable illnesses, like any other medical conditions. As stated earlier, German psychiatrist, Emil Kraepelin, defined affective disorders, which he constructed from the work of a small group of nineteenth century European psychiatrists (Goodwin & Jamison, 1990). Kraepelin's (1921) groundwork evolved into traits and definitions commonly used today in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V). The following is a definition of terms from the National Institute of Mental Health (NIMH) regarding depression and bipolar disorder (NIMH, 2012):

Depression

Major depressive disorder, also called major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life. Depression is referred to as a unipolar disorder. Dysthymic disorder, also called dysthymia, is characterized by long-term, but less severe symptoms that may not disable a person but can prevent one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes. (NIMH, 2012)

Bipolar Disorder

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. Symptoms of bipolar disorder are severe. They are different from the normal ups and downs that everyone goes through from time to time. People with bipolar disorder experience unusually intense emotional states that occur in distinct periods called *mood episodes*. An overly joyful or overexcited state is called a manic episode, and an extremely sad or hopeless state is called a depressive episode. Hypomania is a less severe manic episode. Sometimes, a mood episode includes symptoms of both mania and depression. This is called a mixed state (NIMH, 2012).

There are four different types of bipolar disorder:

1. Bipolar I Disorder is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behavior (NIMH, 2012).
2. Bipolar II Disorder is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes (NIMH, 2012).
3. Bipolar Disorder Not Otherwise Specified (BP-NOS) is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for

either bipolar I or II. The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior (NIMH, 2012).

4. Cyclothymic Disorder, or Cyclothymia, is a mild form of bipolar disorder.

People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years. However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder. (NIMH, 2012).

Living With Bipolar Disorder

Bipolar disorder is significantly underdiagnosed. It generally takes twenty years to be formally diagnosed, with the onset of symptoms starting at 19 years of age. This puts the average age of bipolar disorder diagnosis at approximately age 40 (Ghaemi, Sachs, Chiou, Pandurangi, & Goodwin, 1999). Three to five percent of the population lives with the disorder; type I bipolar disorder being split equally among males and females, and type II bipolar disorder being more common in females (Ghaemi et al., 1999). Bipolar disorder is hereditary and the most genetic major psychiatric condition (Ghaemi et al., 1999).

Living with bipolar disorder is an ongoing battle with oneself. Accepting the diagnosis is the difficult first step in a series of challenges for those with one of these mood disorders. It can take years to come to terms with the diagnosis and can be very difficult to understand. To fully grasp what a person feels and experiences, phenomenological interviews provide the best opportunity for rich descriptions in a

qualitative study, allowing the both the researcher and reader to feel the experiences of the participant (Ponterotto, 2006). In the review of literature on mood disorders, finding these types of studies was of particular interest to truly understand what life is like for those affected with depression or bipolar disorder. In their study, Jönsson et al. (2008) asked patients to describe their views of their mental illnesses, as well as their views of the future. From these interviews, six common themes emerged. Those first four themes that were revealed were 1) acceptance of the depression or bipolar disorder diagnosis, 2) feelings of insecurity, 3) understanding the diagnosis, and 4) management of the illness are ways in which these patients view life with depression or bipolar disorder. Many felt it was troublesome to be labeled as having a mental illness, which was the major factor in accepting the diagnosis. Part of this difficulty is the social stigma, which are discussed later in this chapter. The feelings of insecurity and self-doubt were prevalent among the participants. The more the patients learned about their disorder, the more they were able to understand and manage their illnesses (Jönsson et al., 2008). When inquiring about the participants' views of the future, two dichotomous themes were discovered: that of an uncertain future or a hopeful future. According to a 23 year old female from their research study, younger participants seemed to have more uncertainty:

The fear is that your mood might soar or that you might become depressed and unable to do what you have to. . . you don't dare to have long-term goals and dreams because you know that you are totally chaotic. You do not dare to dream. (Jönsson et al., 2008, p. 1229)

However, through gaining knowledge about the illness, accepting the diagnosis, and taking responsibility for positive action and management, the more hopeful this 57 year old female participant became:

I believe that to a great degree it depends on the individual... that you have to fight it. Mmm, not just being passive and doing nothing. I have to use all the resources that I had when I was studying because then I had a great deal of resources. I try to put them to use to make life as good as possible. (Jönsson et al., 2008, p. 1229)

Other qualitative studies on depression or bipolar disorder show similar findings regarding the ongoing struggles of daily life, the difficulty in finding balance between depression and mania, and the uncertainty of the future. For example, findings suggest there is a strong relationship between social support and the quality of life for a person with depression or bipolar disorder (Michalak et al., 2006). This social support includes support from family, friends, peers, medical personnel, educators, and the community at large. While qualitative research has limitations, in that “statistically valid generalizations cannot be made on the basis of the data, nor can causal relationships be established” (Michalak et al., p. 36), these phenomenological studies do allow for greater understanding of the experience of life with depression or bipolar disorder.

Social Stigma Regarding Depression or Bipolar Disorder

That’s the way it is with mental illness. They say that there are no prejudices anymore, because people are so enlightened, but that isn’t true. They look askance at you and think, “Hmm she’s mentally ill and her behavior is different and at

times they don't believe what you say... and that may be the reason why I find it difficult to accept the illness.” (Jonsson et al., 2006, p.1225)

There is a negative social stigma surrounding mental health issues, but particularly bipolar disorder. The illness is linked to substance abuse, suicide, particularly during a depressive episode, and erratic, inappropriate behavior, particularly during a manic episode. Those affected with bipolar disorder are more likely to seek help during a depressive cycle rather than during a manic one (Goodwin & Jamison, 1990). In fact, the high, euphoric, extreme joy experienced during a manic episode is so powerful that most people with bipolar disorder wish to remain in this state. Life is intense, energetic, and ecstatic. Many people in this state accomplish a great deal. However intoxicating, with mania also comes inflated self-esteem, impulsivity, reckless behavior, and poor judgment, often resulting in irresponsible decisions (Goodwin & Jamison, 1990).

After a manic episode, which can last for days, weeks, or years, a person with bipolar disorder usually crashes to a depressive state, accompanied with feelings just as powerful as those during mania, but on the other end of the emotional continuum. These include extreme feelings of shame, humiliation, worthlessness, hopelessness, and often thoughts of suicide. Kraepelin (1921) concluded that during a depressive state, a person's “heart is heavy, nothing can permanently rouse his interest, nothing gives him pleasure” (p. 76).

During the manic phase, the consequences of any erratic behavior or bad decisions made are painful to realize and difficult to repair. Outsiders do not understand this bizarre behavior and are often very judgmental. Most participants with depression or bipolar disorder stated during interviews that having a mental disorder was looked upon

unfavorably by others, much more so than having a physical disorder (Michalak et al., 2006). They felt judged by society and often discriminated against, particularly in the workplace. This social stigma can lead individuals to not fully disclose their illness, having a sense of withholding a terrible secret, and living with a great deal of shame, guilt, and self-doubt (Michalak et al., 2006).

Bipolar Disorder in School Settings

Bipolar disorder can mimic other illnesses, such as post-traumatic stress disorder (PTSD) and phobias, attention deficit hyperactivity disorder (ADHD), and other affective disorders, such as unipolar depression and personality disorders. Depression or bipolar disorder can also sometimes co-exist with some or all of these disorders and illnesses. Depression and bipolar disorder are both also very commonly linked with alcoholism and substance abuse. It is unclear whether depression or bipolar disorder causes a person to self-medicate, thus turning to drugs and/or alcohol, or whether the use and abuse of these substances causes mania and depression (NIMH, 2012). This is why bipolar disorder is so often difficult to diagnose, particularly in children and adolescents (Goodwin & Jamison, 1990). As a result, there are many students of all ages in schools who have an undiagnosed mental illness and are in need of intervention. Bipolar disorder has traditionally been described as an adult disorder. There is controversy whether the illness even exists in children (Youngstrom, Birmaher, & Findling, 2008).

There have recently been several qualitative studies investigating the phenomenology of pediatric depression or bipolar disorder (Hatchett, 2009; Killu & Crundwell, 2008; Youngstrom et al., 2008). Much of the findings indicate difficulty in diagnosing pediatric depression or bipolar disorder, because of the presence, or lack

thereof, of elated moods (Youngstrom et al., 2008). The presence of elated moods aids in the diagnosis of bipolar disorder, but because these elated moods are not required to be present in order to diagnose bipolar disorder, pediatric bipolar disorder often goes underdiagnosed, undiagnosed (Youngstrom et al., 2008), or misdiagnosed as unipolar depression or another mental illness. This is especially troublesome in evaluating children, where elevated moods, both positive and negative, can be a part of normal childhood behavior.

Although difficult to diagnose, the general consensus amongst psychiatric practitioners is that pediatric bipolar disorder does exist (Hatchett, 2009). This presents many challenges in the educational system. School counselors have little training in the *Diagnostic and Statistical Manual of Mental Disorders*, but these counselors, along with classroom teachers, are crucial in identifying mental illnesses in children and adolescents. It is typical that, until recently, young people have often been misdiagnosed with attention deficit hyperactivity disorder or other behavioral and/or emotional disorders when in fact they possibly have a mood disorder like bipolar disorder or depression (Hatchett, 2009). Children and adolescents with depression or bipolar disorder have a greater risk for failure in school (Killu & Crundwell, 2008). Killu and Crundwell (2008) recommend several strategies for classroom interventions in dealing with pediatric depression or bipolar disorder. These strategies include “modifications in classroom accommodations, modifications in examination and assignment accommodations, and modifications in behavior management and social accommodations” (p. 247).

Bipolar Disorder in Post-Secondary Educational Settings

Federman's 2011 research on the effective treatment of university students diagnosed with bipolar disorder states that the majority of university students with bipolar disorder are referred to counseling centers outside the university system for treatment of the illness. Federman (2011) makes a case for the need to treat these students on campus at college counseling centers to help these students effectively manage their bipolar disorder. Federman (2011) offers a four point rationale for the need to treat bipolar students on site: 1) when students are treated on campus along with off-campus support, students are more likely to receive consistent support rather than episodic support; 2) since the symptoms of bipolar disorder, especially symptoms of mania can occur rapidly, students need to receive treatment at a center with rapid response capabilities so the students can be seen shortly after the onset of emerging symptoms; 3) the bipolar student may require academic accommodations and case management advocacies which are best utilized with help from professors and university deans; 4) by treating the bipolar student at college counseling centers, the students will have a more meaningful connection to the university counseling center and the university in general which is essential in successful management protocol of bipolar disorder. "The recommended treatment protocol for students with bipolar disorder entails three core components: psychiatric medication, individual psychotherapy, and participation in a bipolar support group" (Federman, 2011, p. 28). It is through this approach that universities can best serve these individuals with a successful outcome. As stated earlier, acceptance is a key component in the management of bipolar disorder. Treating bipolar students within the borders of the university will provide students the support to live within the context of self-acceptance rather than denial.

While most individuals who are afflicted with mood disorders and other psychiatric illnesses are not violent (NAMI, 2012), some individuals can become violent in very extreme cases. Since the 2011 shooting of U.S. Representative Gabrielle Giffords at a grocery store by a community college student in Arizona, the role of college personnel in identifying troubled students has become paramount in the educational global conversation in preventing such tragedies, in this case which left Giffords critically injured and six others fatally wounded. The shooter, Jared Lee Loughner was expelled from Pima Community College in 2010, four months prior to the shooting, because Loughner was “a cause for concern for college staff” (Allman, Valentine & Valentine, 2012, p. 46). Loughner was ultimately diagnosed with severe schizophrenia and declared unfit to stand trial (Slapper, 2011). The educational community as well as the community at large has posed the question, what could the college have done differently to prevent this tragedy? While colleges and universities are certainly not in the business of diagnosing mental illness, the fact remains that being equipped to provide support to students with mental disorders is necessary. Research (Allman et al., 2012) into the links between emotional disturbances and learning will lead to better understanding and allow educational communities to better serve students and society at large. Providing support to this student population is the first step in helping students with mental disorders successfully manage their illnesses.

The college years are developmentally a very complex time. Students are exploring and defining their physical and mental boundaries. Campus life is also complex; it is not unusual to have erratic sleep patterns, drink alcohol, experiment with drugs, and experience intense relationships. All of these factors complicate the treatment

of the student with bipolar disorder. Health care providers need to make lifestyle recommendations conducive to the culture of college life. They should help students recognize their mood states and develop management strategies that promote stability (Lejeune, 2011).

Bipolar Disorder and Creativity

And Something's odd - within -
 That person that I was -
 And this One - do not feel the same -
 Could it be Madness - this?

-Emily Dickinson (Jamison, 1993, p. 49)

Creativity and manic depression (bipolar disorder) have been linked for centuries (Jamison, 1993). There has been a fascination surrounding this concept, from the writings of early philosophers in ancient times about genius and madness, to the 1993 publication of Kay Redfield Jamison's landmark book, *Touched With Fire*, which examines the connection between bipolar disorder and creativity. Much research has been done on numerous great writers, artists, and musicians of yesteryear, such as Vincent Van Gogh, Emily Dickinson, and Robert Schumann. It is possible to speculate about the mental health of these artists by examining memoirs, letters and journals of the day, and most importantly, the prolific work created by each artist. Regarding Emily Dickinson, Ramey and Weisberg (2004) state:

Dickinson is one of America's best known poets, as well as the quintessential example of the enigmatic artist with a tortured mind... Her immense corpus of work, some 1,700 poems, was first discovered only

posthumously. At her death, Dickinson expressed the desire that her poems be destroyed. Dickinson's sister Lavinia, who served as executor of her estate, did not follow those instructions and, instead, began to have the verse published... Death, solitude, and loss were recurring themes in Dickinson's poetry, expressed sometimes in first-person descriptions of the poet's own death. (p. 175)

The controversial issue that emerges in many studies on bipolar disorder is that of causality. Kraepelin (1921) hypothesized that mania brings out different ways of thinking, and thus “sets free” the creative self, which has been hidden or untapped by inhibitions (Weisberg, 1994). Thus using this precept, mania causes creativity. Many studies have shown that there is a higher incidence of depression or particularly bipolar disorder in creative people versus in control groups (Andreasen, 1987; Jamison, 1993; Ramey & Weisberg, 2004). While these studies have revealed that there is a significant correlation between bipolar disorder and creativity, the actual cause of this correlation has not been proven. Andreasen's (1987) study of creative writers at the University of Iowa Writers' Workshop revealed that 80 percent of the writers had an affective disorder, versus only 30 percent in a control group, and 43 percent of the writers had bipolar disorder in particular, versus only 10 percent in the control group. While these findings have implications for how creativity is viewed in the context of mental health concerns, Andreasen's 15 year study was criticized on methodological grounds, with respect to the fact that her participant selection process started with individuals already deemed creative, and did not provide a random sample of writers (Anderegg & Gartner, 2001). Schlesinger (2009) also points out that the Iowa Writers' Workshop is known for being a

retreat of sorts for writers who are burned out and in need of rejuvenation, thus representing a high percentage of troubled writers.

“Studies in the Creative Process,” a 30-year study at Harvard University examined many creative individuals in over 2,000 hours of interviews. The findings in this study showed that the only common trait amongst creative people was motivation (Schlesinger, 2009). While popular culture has seemed obsessed with the mysterious notion of the tortured artist or mad scientist, and studies have shown that many creative people experience mania and depression, these studies do not offer support for Kraepelin’s (1921) hypothesis that mania sets creativity free (Weisberg, 1994). Perhaps creativity, and the resulting productivity of that creativity, are what cause mania? Ramey and Weisberg (2004) pose the question that prior evidence linking mood disorders to creativity is subject to interpretation. They suggest that perhaps positive mood and high motivation are the driving forces behind creativity.

Mood Disorders and Self Esteem

There is evidence that abnormal self-esteem is present in bipolar disorder (Knowles et al., 2007). During a depressive episode, self-esteem is deflated. Persistent feelings of worthlessness, self-doubt, and insecurity are eminent. On the other hand, during a manic episode, self-esteem is inflated. Extreme goal-setting, grandiose thoughts, and euphoria make the manic person seemingly invincible. Research studies indicate that bipolar disorder is associated with positive mood disturbance (Gruber et al., 2008; Knowles et al., 2007). Studies have also shown that negative cognitive thought processes and dysfunctional thinking are present in depression and bipolar disorder, and is exhibited through perfectionism and an overwhelming need for approval from others

(Eisner et al., 2008). However, it is uncertain if feelings of low self-esteem cause depression and feelings of high self-esteem cause mania. There have been several studies linking goal achievement and reward seeking to manic episodes (Eisner et al., 2008; Johnson et al., 2000; Knowles et al., 2007). In their examination of undergraduate and graduate students during final exams at the University of Wisconsin, Nusslock, Abramson, Harmon-Jones, Alloy & Hogan (2007) hypothesized that even the pursuit of a goal is associated with the onset of hypomania. As one participant shared, “I am most up when I am working toward something, when I am out of my rut, because I love to tackle the impossible... It is a euphoric but serious mood that almost drives you to be distracted” (p. 113). Although the findings in this study suggested that there is a correlation between goal pursuit and hypomania, there were limitations, in that other conditions which can cause manic episodes were present, such as sleep deprivation.

Research does indicate that bipolar disorder patients in general suffer from low self-esteem (Winters & Neale, 1985), but there is limited literature on the relationship between high self-esteem and bipolar disorder. Research suggests that goal achievement can predict manic episodes (Johnson et al., 2000). Goal achievement results in feelings of self-worth and happiness, thus raising self-esteem. Is it possible then that a boost in self-esteem could induce a manic episode? Further research in this area would add to the existing literature on bipolar disorder and provide additional opportunities for understanding and managing bipolar disorder.

Bipolar Disorder and Childhood Abuse

Sadly, many people with bipolar disorder have a history of childhood abuse. This can be a contributing factor to the onset of bipolar disorder (Garno, Goldberg, Ramirez & Ritzler, 2004).

Our results suggest that a history of severe childhood abuse is to be found in approximately half of adults with bipolar disorder, with multiple forms of having occurred in about a third. Distinct negative impacts on clinical outcome were associated with childhood physical, sexual or emotional abuse histories, with evidence suggesting more extensive suicidality, rapid cycling and possibly comorbid substance misuse associated with multiple forms of childhood abuse. (Garno et al., 2004, p. 3)

Further quantitative data also suggest a higher instance of childhood abuse amongst adults with bipolar disorder as opposed to unipolar depression (Hyun, Friedman & Dunner, 2000).

The issue of childhood abuse in bipolar patients is an issue that surfaces in many of the stories from adults clinically diagnosed with bipolar disorder. With further study in this area, perhaps the link between childhood abuse and bipolar disorder can be more fully understood, and recommends for earlier intervention for individuals with bipolar disorder and their families can be utilized.

Bipolar Disorder and Gender

Research studies have indicated that depression is twice as common in women as men; however, bipolar disorder showed no significant distinction in the diagnoses of men and women (DiFlorio & Jones, 2010). In their study, DiFlorio and Jones (2010) stated that “No consistent gender differences have been found in a number of variables

including rates of depressive episodes, age and polarity of onset, symptoms, severity of the illness, response to treatment and suicidal behavior” (p. 437). However, it was also found that certain particular life events relating to gender, namely a woman’s menstrual cycle, menopause, and most importantly childbirth, could trigger a bipolar episode:

There is very strong, clear and consistent evidence of a specific relationship between bipolar disorder and childbirth (Jones et al., 2010). It is estimated that women were over 23 times more likely to be admitted with an episode of bipolar disorder in the first postpartum month. For postpartum episodes on the bipolar spectrum there is a characteristic and close temporal relationship to childbirth. (DiFlorio & Jones, 2010, p. 448)

While gender is not the most important factor in determining successful management and coping strategies in bipolar disorder, it is certainly important to understand the gender differences in the presentation of symptoms of bipolar disorder and the variations in approach to successfully manage the disorder.

Successful Management of Bipolar Disorder

A 2011 qualitative study on the successful self-management of high functioning adults diagnosed with bipolar disorder identifies six common strategies for living well with bipolar disorder. The strategies are: (1) sleep, rest, diet and exercise, (2) ongoing monitoring, (3) reflective and meditative practices, (4) understanding BD and educating others, (5) connecting with others and (6) enacting a plan (Murray et al., 2011, p. 99).

Our novel qualitative investigation of self-management strategies used by people who are coping well with bipolar disorder generated two incremental advances. First, we were able to give voice to the positive well-being strategies that are

found effective by people who are diagnosed with bipolar disorder, and indeed have a significant mental illness history. This is important data because it provides a hopeful narrative, critical for clinicians and their clients as they approach the challenge of managing bipolar disorder. Second, by integrating qualitative data with existing quantitative knowledge about effective psychosocial treatment strategies we were able to provide a more contextualized set of cognitive behavioural guidelines for clinicians to apply in their therapeutic collaborations. (p. 107)

This research is one of the most comprehensive qualitative studies on successfully managing bipolar disorder, namely, the self-management of bipolar disorder. Many researchers agree that self-acceptance and knowledge about the disorder are cornerstones for recovery (Goodwin & Jamison, 1990; Jönsson et al., 2008; McManamy, 2006).

Clinicians and patients also agree that getting adequate sleep is one of the most important factors in staying well with bipolar disorder (Jamison, 1993; McManamy, 2006; Murray et al., 2011).

Some participants emphasized the benefits of sleep and naps on a routine basis whereas others described the association between sleep and rest to symptoms of mania and depression. One person explains, “I guess another boundary that I set is sleep. That I make sure that I get to bed by 10:30 - 11:00 every night. And a routine is really important. So I think those kinds of things. And I wouldn’t say that I’ve been absolutely symptom-free but managing, learning to self-monitor.” (Murray et al., 2011, p. 99)

Research suggests that patients with bipolar disorder have abnormally shifted or arrhythmic circadian systems. “The term *circadian* refers to a time frame of about 1 day and captures an interesting feature of the circadian clock, namely, that it runs slightly longer or shorter than twenty four hours” (Harvey, 2008, p. 823). The human body is highly responsive to *zeitgebers*, timegivers, stimuli in the environment that cue the biological system so that our circadian rhythms become synchronized with the activity in the world around us (Harvey, 2008). This concept supports evidence that inadequate sleep can trigger a bipolar episode.

A 2007 research study in Australia surveyed 8,041 adults, ages 16 to 85, examined the use of traditional, formal management of mental illnesses versus formal management combined with self-management of mental illness (Olesen, Butterworth & Leach, 2010). Olesen, Butterworth, and Leach’s (2010) findings indicated that self-management alone may not be as effective as formal management used along with self-management.

It is possible that self-management alone does not represent adequate treatment for many people. For these people, the absence of formal service use may reflect the presence of a barrier to appropriate treatment. This may include system-related factors or personal barriers, such as stigma and perceptions of the effectiveness or availability of formal mental health services. Our preliminary exploration of formal service use compared to self-management in demographic groups that traditionally receive few formal services (e.g. young adults and men) suggests that the former may play a role. For example, while formal service use

was lower among young adults than middle-aged adults, the use of self-management strategies was approximately equal across these two groups. (p. 828)

This study made recommendations for further research of self-management techniques to explore this strategy as a viable option for successful management of mental illness.

In many studies, successful management of bipolar disorder does not occur without the use of pharmaceutical intervention (Proudfoot et al., 2009; Rusner et al., 2009; Yatham, et al., 2005). Yet there is acknowledgement that prescription drug therapy alone is not as effective as a management plan that includes additional support systems.

Elements would include preparing the patient to become actively involved in self-management, identifying ways to collaborate most effectively with health providers, teaching key facts about bipolar disorder, teaching recognition of early signs of relapse, identifying a relapse drill, and learning a variety of key stress management techniques, including careful attention to sleep regulation and avoidance of substance misuse. Involvement of family or key friends in part of the psychoeducation can be invaluable, particularly in creating a relapse drill.

Effective relapse drills feature creating a document that lists early warning symptoms of relapse and specifies usual treatment responses, including self-management maneuvers. (Yatham et al., 2005, p. 9)

Prescription medication is definitely not the sole answer in the successful management of bipolar disorder, but it plays an important role along with behavioral cognitive therapy and healthy boundaries regarding sleep, diet and exercise.

Conclusion

The review of literature on the topic of living with bipolar disorder provides insight into the life experiences of individuals with the illness, including those in post-secondary school, and the accompanying traits, participant demographics, challenges, and coping strategies. The literature examined the following questions:

- What is the experience of living with bipolar disorder?
- What is the experience of living with bipolar disorder as a college student?
- What is the social stigma surrounding bipolar disorder?
- What are ways to successfully manage bipolar disorder?
- What is the link between creativity and bipolar disorder?
- How does self-esteem affect bipolar disorder? How does bipolar disorder affect self-esteem?
- What are the effects of childhood abuse on bipolar disorder?
- How can educational institutions best serve students in successful management of mental illness disorders?

I believe the links between creativity and bipolar disorder (Jamison, 1993) are important factors in providing outlets for successful management of the illness. The creative outlet can provide opportunities for self-reflection and understanding, which are the first steps on the road to recovery and management (Jönsson et al., 2008). While there are several studies that emphasize important strategies for management of bipolar disorder, such as pharmaceutical intervention (Proudfoot et al., 2009; Rusner et al., 2009; Yatham et al., 2005) proper physical care in sleep, exercise and diet, continued monitoring, reflective and meditative practices, understanding bipolar disorder and educating others; connecting with others, and enacting a plan (McManamy, 2006;

Michalak et al., 2006; Murray et al., 2011), there are no studies that I found which include creative outlet as part of a management plan.

Chapter 3

METHODOLOGY

This qualitative (Creswell, 2007; Merriam, 2002) research study examined the phenomenon of the lived experience (Van Manen, 1990) of women clinically diagnosed with bipolar disorder who are successfully managing the disorder while navigating through post-secondary school. Understanding the essence of the experience and describing the essence of a lived phenomenon, (Creswell, 2007), as well as researching the lived experience and interpreting the “texts” of life (Van Manen, 1990), was the foundation of my work.

The data collection method I used in my study was a narrative interview format (Seidman, 2006) to allow the participant to simply tell her story and share the experience of living (Creswell, 2007) with bipolar disorder, much like in recent research studies on living with the illness (McManamy, 2006; Proudfoot et al., 2009; Rusner et al., 2009). Hearing the participants’ stories allowed me to further understand the life experiences of the participants. The epistemological and philosophical assumptions were constructivist (Crotty, 1998; Mertens, 2010), which are relativist, context bound, and socially constructed (Crotty, 1998; Mertens, 2010).

Research Design

In the preliminary decision stage of initiating a qualitative research design it is important to consider paradigms or worldviews (Creswell, 2007). A researcher’s worldview, or belief system, is the foundation of the research design. Creswell (2007) focuses on four worldviews which shape the focus of research studies: postpositivism, constructivism, advocacy/participatory, and pragmatism (p. 19). Social constructivism

was the focus of my study, because it emphasizes the importance of understanding the world in which we live, and seeks to find meaning, which leads the researcher “to look for the complexity of views rather than narrow the meanings into a few categories or ideas. The goal of research, then, is to rely as much as possible on the participants’ views of the situation” (Creswell, 2007, p. 20). This concept is the driving force in initiating a qualitative research design rooted in a phenomenological approach. In my quest to understand “the who and the why,” collecting data through a narrative interview was predominantly appealing to me. Qualitative research allows for a deeper connection between the researcher and participants (Ponteretto, 2007) where “the researcher and participants become emotively connected, facilitating deeper levels of communication and topic exploration” (p. 582). Sciarra (1999) also emphasizes the importance of this emotional connection as the researcher listens intensely to the participants’ experiences, as well as listens to and respects their own voice and life experiences: “not only are emotions allowed in qualitative research, they are crucial. Because entering the meaning-making world of another requires empathy, it is inconceivable how the qualitative researcher would accomplish her goal by distancing herself from emotions” (pp. 44–45).

Phenomenology

The focus of phenomenological methodology is to understand the essence of the experience, which allows the researcher to describe a lived phenomenon (Creswell, 2007). Conducting interviews with several individuals who have shared the same experience provides the opportunity for developing textural description, answering the question “what happened?” as well as developing a structural description explaining how the phenomenon was experienced (Creswell, 2007). This phenomenological approach

allows us to “hear silenced voices” (Creswell, 2007, p. 40) from a community of people who are sometimes otherwise misunderstood. To fully grasp what a person feels and experiences, phenomenological interviews (Seidman, 2006) provide the best opportunity for rich, descriptions in a qualitative study, allowing the researcher and reader to feel the experiences of the participant (Ponterotto, 2006).

Participants

I interviewed six female adults who have experienced the phenomenon (Creswell, 2007) of living with a bipolar disorder diagnosis, and have attended a post-secondary school. The criteria for the selection of participants (Creswell, 2007) was to find individuals who have experienced the phenomenon of living with bipolar disorder and were able and willing to talk about their experiences.

I accessed these individuals (Kawulich, 2011) through contact with the National Alliance on Mental Illness (NAMI) and other mental health forums, of which I am a member. I contacted a leading member of NAMI and explained my research project. I asked for recommendations for participants who might be interested in sharing their stories with me. Information regarding my research study and need for participants to be interviewed was published in a NAMI newsletter beginning in May 2013. From this inquiry, several individuals contacted me to express a desire to share their experiences. All who contacted me wanted to participate in order to help others understand the dynamics of living with bipolar disorder so that there can be a general greater understanding of this illness. Every individual who came forward was female. While research indicates that just as many men are diagnosed with bipolar disorder as women (Diflorio & Jones, 2010; Ghaemi et al., 1999; Kessing, 2004), there are studies which

show evidence of more women being willing to talk about their experiences with mental illness (MacKenzie, Gekoski, & Knox, 2006). I would have preferred men to be included in my study, but the fact that men are less likely to talk about their personal experiences with bipolar disorder resulted in a deficit of male participants.

My relationship with these participants was as researcher. Participation in a research study can present possible risks, therefore ethical considerations must be addressed. Drew, Hardman and Hosp (2008) state that “the most basic concern in all research is that no individual is harmed by serving as a participant, as suggested by the APA and AERA codes of ethics” (p. 64) and that psychological stress may negatively affect the participant. The risk factors (Drew, Hardman & Hosp, 2008) for participants in my study were the potential of revisiting memories that could create emotional distress, participants could have revealed regrets of past experiences, and there could have been possible expression of emotions such as sadness and frustration. Acknowledging this, participants could have discontinued the interview process at any time if they so chose (Drew, Hardman & Hosp, 2008).

While participant identifying characteristics, such as age and demographics, were included in this research study, no personal participant information, such as the participant’s name and post-secondary school name, which could identify the participant, was included in order to ensure anonymity (Bogdan & Biklen, 2007; Drew, Hardman & Hosp, 2008). Pseudonyms (Bogdan & Biklen, 2007; Drew, Hardman & Hosp, 2008), chosen by each participant, were used throughout the interviews and subsequent research study. Participants were provided with and asked to sign an informed consent form

(Bogdan & Biklen, 2007; Drew, Hardman & Hosp, 2008), (see Appendix A) that addressed the following:

- identifying the research through Drake University
- outlining data collection procedures
- participant confidentiality
- participant right to withdraw from study at any time
- potential risks to participant
- IRB and researcher contact information
- participant compensation of \$10 gift card per interview

I met each participant in a location of their choice. I went to four participants' homes and sat in comfortable living rooms where the participants were candid and relaxed. I went to college conference rooms for two participants who felt they would have more privacy. By allowing each participant to choose the location of the interview, the atmosphere was conducive to thoughtful reflection and allowed the interview to flow like a conversation (Bogdan & Biklen, 2007). I was welcomed by each participant. The words didn't always flow easily from their mouths; some of the experiences shared were excruciatingly painful for the participants to tell and for me to hear. There were sometimes tears and moments of silence as stories were divulged. The participants knew they could stop at any time if it was too difficult (Drew, Hardman & Hosp, 2008). No one stopped. In fact, in almost all six cases, the participants continued on with their life stories, as one interview flowed into the next. It seemed to me as if the telling of their stories had therapeutic value and somehow purged some of the pain. Face-to-face interviews allowed me the opportunity to observe body language and voice inflection,

which provided further validation for the data I collected from these participants. I took field notes (Bogdan & Biklen, 2007) as I listened but I actually did not write too much during the interviews. I was so engaged in what each participant had to say that I mainly just listened. Rather, I wrote in a reflective journal after each interview to record my thoughts, feelings and reactions to what I heard. Bogdan and Biklen (2007) refer to this as “reflective fieldnotes” (p. 122) where the researcher has the opportunity to record his or her subjective feelings and ideas, which further authenticate the research study (Bogdan & Biklen, 2007). I was deeply affected by the experience.

Each interview began with the participant signing a copy of the consent form (Bogdan & Biklen, 2007; Drew, Hardman & Hosp, 2008) (Appendix A), which I had previously sent to each participant for review. Each participant chose a pseudonym (Bogdan & Biklen, 2007; Drew, Hardman & Hosp, 2008) for the interview. The interviews were recorded on two digital audio devices so that I would have a back-up if one device failed. The recordings were then transferred to my personal computer immediately following each interview. I listened to the interviews repeatedly, taking notes as I listened, referred to as *bracketing* (Creswell, 2007). Each interview was transcribed verbatim (Bogdan & Biklen, 2007) and I began coding emergent themes. I communicated with the participants several times after the interviews for follow-up clarification and to see how they were doing. I provided each participant with a copy of my findings, which included verbatim quotes from the transcribed interviews. This ensured the authenticity of the data through member checks (Merriam, 2002).

At the time I started the interview process, I was not sure how many interviews I would conduct, as I awaited data saturation (Bogdan & Biklen, 2007). That is, I waited

until I started to hear recurring elements in the interviews. I began hearing these recurring themes and similar experiences between the participants almost immediately. I was satisfied with six interviews as I coded similar findings.

The sample of participants (Table 3.1), ages 35 to 68, were from the Midwest, all female, all had post-secondary school experience, were all high achieving individuals, and are currently managing bipolar disorder through pharmaceutical intervention and behavior modification. These women were strong, resilient, self-reflective, and courageous. All participants were actively involved in school, from the elementary level to the college level. Three of the participants successfully completed college with bachelor's degrees, two participants successfully completed associate's degrees, two participants are currently part-time graduate students working toward their master's degrees, and one participant completed a master's degree. One participant did not finish college, but rather has a professional certification. Five of the six participants are the first born child in their families, and all have siblings.

Table 3.1 Description of Participants with Bipolar Disorder

Participant	Age	Post-Secondary Accomplishments	School Activities	Characteristics
Meg	36	BA English and French, currently in pursuit of MA	Marching Band, Christian Fellowship Group, Math Club	Intelligent, resilient, spiritual, works as a librarian, married – no children
Christine	35	BA Criminal Justice, graduated Cum Laude	Lettered in music, good grades	Intelligent, resilient, reflective, works in higher education, married - 3 children
Lorraine	68	BA Education MA Social Work	High school Valedictorian, yearbook editor, Thespian, basketball player	Intelligent, resilient, wise, strong, retired Social Worker, married 46 years - three children
Renee	47	AA Liberal Arts Graduated Phi	Marching band, several choirs, color	Intelligent, resilient, strong, creative, works as a Technical

		Theta Kappa	guard, cheerleading	Writer, published author, single mother - two sons
Chloe	51	Professional Certification in Peer Support	Choir, band, writing, straight A student	High IQ, resilient, self-assured, self-employed Certified Peer Support Specialist, single, no children
Lindsay	54	AA Science Dean's List	Music, reading, good grades	Reflective, smart, resourceful, currently on disability for bipolar, disorder, single - two children

Gatekeeping

Gaining access to participants is an important and crucial element in qualitative data collection (Kawulich, 2011). “Establishing trusting, long-term relationships through social networking, acquiring specific permissions at various levels, selecting key informants, presenting oneself appropriately, and showing respect for cultural mores are essential aspects of being granted entry by gatekeepers” (Kawulich, 2011, p. 57). I accessed the participants through my affiliation with National Association on Mental Illness (NAMI). I asked for permission from a managing member of NAMI to make connections with adults diagnosed with bipolar disorder who might be interested in participating in my study by telling their stories and experiences in living with bipolar disorder. I asked this managing member of NAMI to serve as gatekeeper for my research study (Creswell, 2007). With guidance from this individual, we identified individuals who are employing techniques for successful management of their disorder as participants for my study. All interview questions were approved by the gatekeeper in advance of the interviews. Utmost respect and confidentiality (Drew, Hardman & Hosp, 2008) of this population was adhered to at all times.

Data Collection

I explored the lived experiences (Van Manen, 1990) and coping strategies of women clinically diagnosed with bipolar disorder who have navigated a post-secondary school experience. The instrumentation was a narrative interview format (Seidman, 2006). Research questions in this type of study should be “highly open-ended, allowing for multiple avenues of research to develop” (Butin, 2010, p. 53). Creswell (2007) recommends the use of a grand tour question as an umbrella, which is guided by underlying questions to support the grand tour question. This dissertation study addressed the following grand tour research question (Creswell, 2007):

What are the life trajectories of women with bipolar disorder that preceded their post-secondary school experiences?

Each interview was approximately one hour in length. One initial interview was conducted for each participant (Seidman, 2006) over a period of one month. Two follow-up interviews were conducted within hours or days of the initial interview. The interviews took place between July and August 2013 in the Midwest. Participants were compensated ten dollars per interview.

The following underlying questions (Seidman, 2006) were used to support the grand tour question (see Appendix B):

- How would you describe living with bipolar disorder?
- How would you describe your school experiences from elementary, middle school, high school and post-secondary education?
- What kinds of experiences, such as support or lack of support for your mood disorder, occurred in the school setting?

- What have been your coping strategies in your management of this illness?
- Are there any creative outlets that help you manage this disorder?

In the data collection stage of qualitative inquiry and design, it is essential to adhere to guidelines that result in a sound research study. Merriam (2002) offers eight strategies for promoting goodness and trustworthiness in a qualitative research study: 1) triangulation, 2) member checks, 3) peer review/examination, 4) the positionality of the researcher, 5) adequate engagement in the data collection, 6) maximum variation, 7) an audit trail, and 8) rich, thick descriptions. While some of these components lend themselves more easily than others, it is crucial to keep these concepts at the forefront of the data collection process, which allows for a more credible analysis of the data (Anfara, Brown & Mangione, 2002). In the design issues section of this chapter, there is further discussion of how I utilized many of these strategies to promote goodness and trustworthiness in my research study.

Delimitations

The delimitations of a study are those characteristics that limit the scope and define the boundaries of the research study (Pyrzczak, 2007). Essentially, a delimitation is a statement of what the study will not cover. My study was delimited to women who have coped with bipolar disorder while navigating a post-secondary degree. I did not address women who are not coping with their disorders while navigating a post-secondary degree, and did not review literature, nor conduct research, about individuals who are not coping with their mood disorders. Rather, I concentrated on the lived experiences of women successfully coping and managing bipolar disorder while navigating a post-

secondary degree. Accordingly, my study was limited to women who are clinically diagnosed with bipolar disorder as opposed to those who are not diagnosed with bipolar disorder. My study was delimited to a small sample of six female adult participants who were willing to share their stories for this research study.

Limitations

My research study had limitations. I sought to tell the stories of six women who have successfully managed bipolar disorder while navigating a post-secondary degree. There is a multiplicity of lived experiences of individuals with this disorder, and I interviewed a mere fraction of this population. My research study was limited to women with bipolar disorder who self-reported their experiences in successfully managing bipolar disorder while navigating a post-secondary degree. A possible weakness in my study is the assumption that the participants were truthful in their answers to interview questions.

Confidentiality and Secured Recording of Data

The confidentiality of each participant was strictly adhered to at all times (Drew, Hardman & Hosp, 2008). Face-to-face interviews were audio-taped. Several follow-up phone calls and emails for clarification and member checks (Merriam, 2002) were utilized. Raw data were transcribed verbatim through a combination of the researcher and a professional transcriptionist. Data were coded by creating coding categories, collapsing categories, and developing sub-categories according to emerging themes (Bogdan & Biklen, 2007). Data were securely stored electronically on a password protected computer. Any hard copy data was stored in a locked file cabinet in my home. All forms

of raw data will be stored for three years until destroyed, following dissertation completion.

Data Analysis

Data analysis, “the process of systematically searching and arranging the interview transcripts, fieldnotes, and other materials that you accumulate,” (Bogdan & Biklen, 2007, p. 159) leads the researcher to the findings of the study. For thorough analysis in qualitative inquiry and design, triangulation of the findings through linking the existing literature with verbatim quotes from the narrative interview is imperative (Anfara et al., 2002). Member checks are also an important part of analysis. By involving the participant in the process, the information obtained from the interview is strengthened (Bogdan & Biklen, 2007). I used member checks by communicating with the participants multiple times after the interviews, which included providing transcripts and my findings to authenticate the data. Other important factors in the analysis stage are to highlight and display the findings through charts and graphs, follow and report fieldwork procedures, identify patterns and code them accordingly, and compare findings with other cases or standards (Bogdan & Biklen, 2007). To me, this was the exciting and fulfilling stage of the qualitative inquiry and design process, as I began to understand the experiences of the participants and began to draw conclusions.

The narrative writing format is the culmination of the qualitative research process. It is at this point that the participant’s story is told. It is also at this stage that it is crucial to adhere to guidelines which ensure goodness and trustworthiness (Anfara et al., 2002).

The problem is that qualitative researchers do not always provide their readers with detailed explanations of how research questions are related to data sources,

how themes or categories are developed, and how triangulation is accomplished.

Although researchers claim to utilize triangulation and member checks and discuss the development of the themes presented, what is actually done is often anyone's guess. Most studies do not reveal these inner workings, and good writing can cover up awkwardly collected and poorly documented fieldwork. (p. 30)

With awareness of these potential weaknesses in a qualitative study, as stated earlier, I strictly adhered to Merriam's (2002) following strategies for promoting goodness and trustworthiness in a qualitative research study: 1) member checks, 2) peer review/examination, 3) the positionality of the researcher, 4) adequate engagement in the data collection, 5) maximum variation, 6) an audit trail, and 7) rich, thick descriptions.

Data Codification

After reading the collection of data obtained through narrative interviews, I looked for patterns which were sorted into coding categories (Bogdan & Biklen, 2007).

Particular research questions and concerns generate certain categories. Certain theoretical approaches and academic disciplines suggest particular coding schemes. It is far beyond the scope of this book to lay out all the coding categories and theoretical approaches that might be used to develop coding systems. What we will do is provide a list of families of codes to suggest some ways coding can be accomplished. (p. 173)

From Boglan & Biklen's (2007) coding families, I utilized strategy codes which "refer to the tactics, methods, techniques, maneuvers, ploys, and other conscious ways people accomplish various things" (p. 177). As I saw patterns and categories in ways the participants accomplish successful strategies in managing bipolar disorder, as well as

patterns in the participants' backgrounds, I began to collapse categories and develop sub-categories (Bogdan & Biklen, 2007) to further sort my data into common themes that emerged from the data.

Emergent Themes

In my research interviews, I gained great insight into the life of a woman diagnosed with bipolar disorder. All six participants were eager to tell their stories, and I began seeing common themes almost immediately. The main themes of categories that emerged were (Table 3.1):

- Home and family life
- The experience of the onset of bipolar disorder,
- School involvement/achievement
- Successful coping strategies

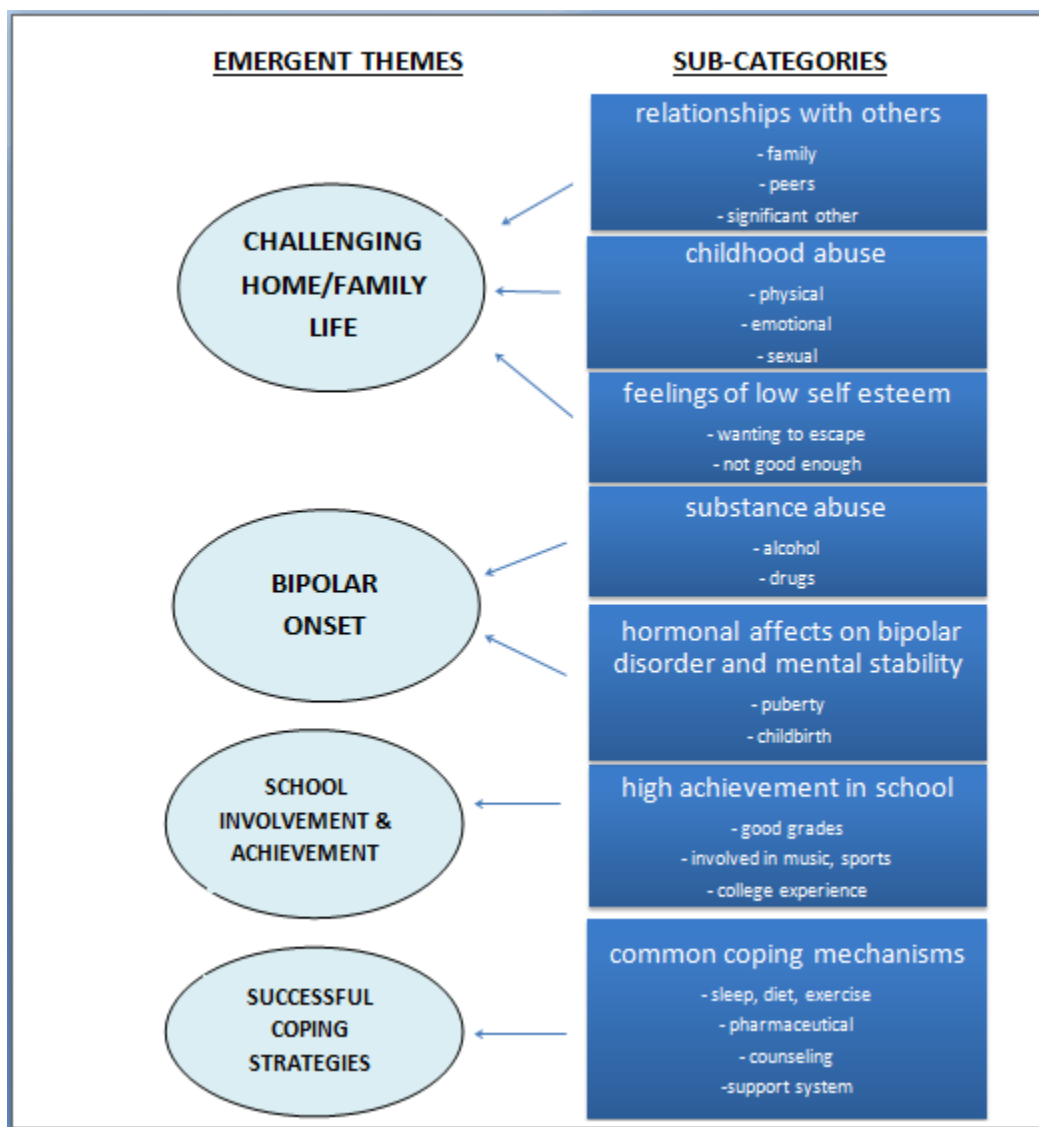
The subcategories under the themes were:

- Relationships with others
- Childhood abuse
- Feelings of low self-esteem and wanting to escape,
- Substance abuse
- Hormonal effects on bipolar disorder and mental stability
- High achievement in school
- Common coping mechanisms.

Another very important recurring theme was that none of the participants shared their mental instability during post-secondary school with any educational professional. The

need to hide the truth regarding possible mental illness or ask for help and accommodations was common amongst all participants.

Figure 3.1 Collapsed Categories and Themes



Design Issues

I used Merriam's (2002) strategies for promoting goodness and trustworthiness in a qualitative research study: member checks, peer review/examination, the positionality of the researcher, adequate engagement in the data collection, maximum variation, an

audit trail, and rich, thick descriptions (Merriam, 2002). As stated earlier, member checks (Merriam, 2002) were an important part of promoting goodness and trustworthiness in my research. I communicated several times with the participants at length after the interviews and provided each with a copy of my findings, which included verbatim quotes from the participants. I asked for their feedback to ensure I was providing authentic representation of their experiences. This process allowed for even deeper understanding and insight into the participants' lived experiences.

Peer review and examination (Merriam, 2002) lent itself easily as I submitted my research study to my dissertation committee for feedback and multiple revisions. I also shared my findings with educational colleagues. I clearly stated my research positionality (Merriam, 2002) to the gatekeeper of my study and, most importantly, to the participants, which provided for adequate and active engagement (Merriam, 2002) during and after the data collection process. Through careful examination of the interview transcriptions, I was able to provide thick description (Merriam, 2002) of the participants' experiences in my findings, rich with detail in order to contextualize my research findings. An audit trail (Merriam, 2002) was utilized as I gave "a detailed account of the methods, procedures, and decision points" (Merriam, 2002, p. 31) carried out in my study.

Maximum variation (Merriam, 2002) of the participant sample is another strategy to ensure goodness and trustworthiness in qualitative research. Although the participants in my research shared similar experiences in living with bipolar disorder, I utilized maximum variation by selecting participants with diverse demographics and backgrounds, such as age, post-secondary school experience, and socio-economic background.

The logic behind this strategy is that if there is some diversity in the nature of the sites selected... or in the participants interviewed, or times and places of field visits, results can be applied to a greater range of situations by readers or consumers of the research. (Merriam, 2002, p. 29)

I also used the work from Anfara et al. (2002) regarding the four concepts to achieve trustworthiness in a qualitative study. The first important concept is credibility, which ensures the findings are those of the respondent and not the researcher. The strategies I employed to achieve credibility were prolonged engagement in the field, use of peer debriefing, member checks, and time sampling (Anfara et al., 2002). The second concept is transferability, which allows the reader to make the judgment if the results can be transferred. The strategies I employed to achieve transferability were providing thick description and purposive sampling (Anfara et al., 2002). The third concept is dependability. Since the data cannot be replicated as it dealt with multiple realities of each participant, reliability is rejected. The dependability of the data was authenticated through the lived experiences and stories told by the participants. The strategies I employed to achieve dependability of the data were creating an audit trail, coding and decoding the data, and peer examination (Anfara et al., 2002). The fourth concept is confirmability. As the researcher's view is subjective, I adhered to the data which confirms the data. The strategy I employed to achieve confirmability was practicing reflexivity (Anfara et al., 2002).

Reflexivity, similar to researcher positionality, is the researcher's use of self-reflection which "allows the reader to better understand how the individual researcher might have arrived at the particular interpretation of the data" (Merriam, 2002, p. 26). I

utilized this strategy by including deep self-disclosure at the conclusion of my research study.

Conclusion

This chapter outlines the methods I used in my qualitative phenomenological research study. This included the epistemological and philosophical assumptions, phenomenological research, narrative interview format, research design, data collection and analysis, participant demographics and confidentiality, and limitations and delimitations. This chapter also included design issues relating to confirmability, dependability, transferability, and credibility (Anfara et al., 2002) as well as Merriam's (2002) eight strategies for promoting goodness and trustworthiness in a qualitative research study: member checks, peer review/examination, the positionality of the researcher, adequate engagement in the data collection, maximum variation, an audit trail, and rich, thick descriptions.

My goal as researcher in this phenomenological study was to allow the participants to share their lived experiences (Van Manen, 1990) and interpret the texts of life (Van Manen, 1990) with bipolar disorder while navigating a post-secondary degree. Through this research, I gained insight into the management of bipolar disorder and identified successful strategies that will bring hope and clarity to those affected with bipolar disorder along with the educational community and the community at large.

Chapter 4

Findings

Introduction

This qualitative research study allowed me the opportunity to hear the personal stories of six women with post-secondary school experience who have been diagnosed with bipolar disorder. As I heard very similar experiences and feelings from the interviewees, I very quickly observed commonalities in these stories which led me to a greater understanding as an educator and a mental health advocate and consumer. I believe these findings could help the educational community at large further understand ways to identify and help these individuals.

I began my dissertation journey by reviewing existing literature on the experiences of individuals with bipolar disorder. After sifting through many research studies, I found that there were not many studies on the college experiences of individuals with bipolar disorder. I found a few quantitative studies, but I really wanted to hear the personal stories of people who navigated through post-secondary school. As an educator, this was of particular interest to me. As a mental health consumer myself, it was also important to me to help shed light on bipolar disorder, and give a voice (Creswell, 2007) to the real people affected with the disorder. I chose a qualitative, phenomenological approach to my research for this reason.

I began by focusing on my research question, “What are the life trajectories of women with bipolar disorder that preceded their post-secondary school experiences?” From this overarching question came other supporting questions about childhood experiences; family dynamics, school experiences, onset of bipolar symptoms and

triggers, and coping strategies (Appendix B). I contacted a Midwestern NAMI chapter and met in person with a leading member and shared my proposed research study with her. My study was met with interest and enthusiasm from this NAMI member, who published my need for participants in a NAMI newsletter. I was also referred to another leader in the Midwestern NAMI chapter who served as the gatekeeper for my study. I submitted my interview questions to her to make sure the questions were appropriate and ethically sound, and she quickly gave her feedback and approval. I began to receive phone calls and emails from individuals, almost immediately, who were eager to share their life stories with me. I proceeded with both anticipation and excitement. I would soon be meeting face-to-face with real people who would share with me their personal accounts of life with bipolar disorder. I looked forward to each of these interviews, as I could hear the personal feelings and experiences of each interviewee, fresh with emotions and context, unlike simply reading research as I did for my literature review. This was the real thing. It was at this point I felt like a true researcher.

The process of interviewing the participants was intense; hearing such personal accounts about living with bipolar disorder, the trials and tribulations of the participants, and the sometimes heartbreaking details of their personal experiences. The awareness I gained deeply affected me as a researcher, educator, and compassionate human being. This qualitative approach of narrative interviews, allowed me the opportunity to not only hear the participants' stories, rich with detail, but also to empathetically experience the participants lives (Ponterotto, 2006). I would not have been awarded this experience through a quantitative approach. I am certain the phenomenological methodology I used for my study was the right choice as I discerned the best research design for my study.

The findings in this research study are centered around four theme categories: home and family life, the experience of the onset of bipolar disorder, school involvement/achievement, and successful coping strategies. The subcategories under the themes were relationships, childhood abuse, feelings of low self esteem and desire to escape, substance abuse, hormonal affects on bipolar disorder and mental stability, high achievement in school, and common coping mechanisms.

Participant Backgrounds

Meg is a 36 year old Caucasian woman who grew up in a supportive, Christian home. She was a high-achieving student involved in marching band, math club, and a Christian fellowship club. Her onset of bipolar disorder was when she was 13 years old when she felt a chemical change in her body. Meg received much support from her parents and two younger siblings as she experienced mood shifts and other difficult times revolving around her bipolar disorder. She successfully completed a bachelor's degree in English and French and taught high school for one year before becoming a librarian. Meg is intelligent and grounded. She is married and has no children.

Christine is a 35 year old Caucasian woman who grew up in a troubled home. She suffered emotional and physical abuse from her mother and step-father. She did well in school and was involved in vocal music. Her onset of bipolar disorder was at age 16 when she began acting out. Christine's most severe symptoms occurred after childbirth. She has a history of substance abuse and toxic relationships. She received a bachelor's degree in Criminal Justice and is currently working toward a Master's degree in Education. Christine is very resilient and reflective. She is married and has three children.

Lorraine is a 68 year old Caucasian woman who grew up in a supportive home where education was highly valued. She did extremely well in school and graduated valedictorian of her senior class in high school. Lorraine's onset of bipolar disorder was after the birth of her first child, when she was placed in a psychiatric hospital for five months and received numerous electric shock therapy treatments for post-partum psychosis. Lorraine received a bachelor's degree in Education and taught school for one year prior to her onset of bipolar disorder. She received her master's degree in Social Work at age 50 and worked with the elderly at a hospital until her retirement in 2010. Lorraine is well-spoken and wise. She has been married for 46 years and has three children.

Renee is a 47 year old Caucasian woman who grew up with physical and emotional abuse from her step-father. She did well in school and was involved in many activities such as choir, band, color guard, and cheerleading. She began acting out at age 14 and started using drugs. Renee was told by her stepfather that she would never amount to anything. There were strict expectations at home which resulted in Renee being a perfectionist and extremely hard on herself. During Renee's teen years and the onset of bipolar disorder, she tried to commit suicide. She attended junior college and although it took Renee 12 years, she completed her Associate's Degree in Liberal Arts in her mid-thirties. Renee is a technical writer and just published her first novel. She is single and has two sons. Renee is a survivor.

Chloe is a 51 year old Caucasian woman who grew up a victim of physical and emotional child abuse. She also witnessed her father physically abuse her mother. She performed very well in school and was gifted academically. Chloe was involved in school

in music and writing. Her onset of bipolar disorder started at age 16 when she began acting out with feelings of wanting to escape. She attempted college several times and received excellent grades, but dropped out each time she became overwhelmed she. Chloe abused drugs to numb her emotional pain. After getting help she moved forward. All the adversities she faced in her life forced her to work harder and she completed professional certification in Peer Support. Chloe uses these skills in her work today by helping others with mental health issues as a self-employed contract Peer Support Specialist. She volunteers for NAMI and has served on NAMI governing boards. Chloe is resilient and very proud of her success.

Lindsay is a 54 year old Caucasian woman who was sexually abused as a child and again as a teenager. She performed very well at school and described herself as a “wonder student.” In fourth grade she began to experience feelings of extreme sadness and constantly thought of death. Lindsay began drinking alcohol at a young age to cope with her pain and was taken to a psychiatrist for depression when she was 14 years old. Soon after this she was sent to a mental health institution for one month and was heavily medicated. Lindsay has bounced back and forth between depression and mania all her life. She has a history of drug abuse and has tried to commit suicide ten times. Lindsay attempted a four-year college program twice and eventually earned an Associate’s Degree in Science, but has been on disability for many years because of her bipolar disorder. She is soft-spoken and caring. Lindsay is single and has two grown children.

Home and Family Life

Two of the six participants had fairly normal upbringings in the Midwest, with supportive families, where education was highly valued. Both Lorraine and Meg grew up in homes with both parents, both with stable home environments. Meg recalled:

My dad is a pastor in the Christian Reformed Church, so our faith and our church has always been really important to our family. And I'd say learning and education is important to us, too. My dad went back to get a PhD when we were like middle school age. My brother has a PhD, my sister is getting one, so that gives you a little flavor I guess for our family.

Meg spoke fondly about spending time camping and enjoying the outdoors with her family. She felt her family was always very supportive of her and continues to be so today. Meg's parents were always there for her through her many difficult experiences, and they quickly came to her aid whenever she needed help.

Lorraine grew up in a small town in the Midwest and is the oldest of four children in her family. "Education was really pushed as a high priority" in her family and her father always made sure his children performed well in school, having always wished he had more education himself. Lorraine stated that her siblings were all professionals and that she has also done well.

I think our childhood was fairly normal. My dad had a gas station; my mom was a homemaker. We went on vacations, there was no substance abuse, although our mother was diagnosed with bipolar late in life, although she probably had it most of her life.

Lorraine did not remember her mother's later onset bipolar disorder affecting her as a child, although she did remember her mother was depressed at times, despite always "trying to put on a happy, smiley face."

The other four participants' experiences were quite different stories, as each revealed childhood abuse in their pasts. Renee's childhood was a traumatic and abusive one because of her stepfather, although outward appearances suggested otherwise, "Believe me... he was the ultimate father in public. In fact, years later, after he died, my neighbor actually thought I was lying when I told him what Bill was really like behind closed doors. He was a perfect neighbor - always helping people." Although her stepfather was gone during the week working as a truck driver, he made up for his absence on the weekends by making life a living hell for his stepchildren. A product of an abusive childhood himself, he would commence with the usual "Saturday night beatings."

If my mom didn't have anything to tell him that we did wrong, he would make something up. He would use my belt because I was the smallest and had the thinnest leather belt. I even remember the belt. It was brown leather with a metal clasp with a holographic Scottie dog on it. He would line us up and let the beatings commence. My brother probably got it the worst, because he was 'the oldest, therefore must set an example.' Even when I was 4 - 5 years old, I got beat - not spanked. We're talking welts and cuts.

Renee's stepfather expected everything to be perfect and had absurdly high expectations about cleaning the house. She described instances of him

coming home in the middle of the night and inspecting for anything out of order.

“If he found anything- and I think sometimes he just made up that he did- he would wake us up and make us do all our chores right then. Usually by the time we got done, it was time to go to school.” Aside from the physical abuse, Renee and her siblings suffered from emotional abuse, being constantly told that they were bad and would never amount to anything. She felt in many ways this emotional abuse was far worse than the physical abuse, “Words are worse even than broken bones. Broken bones heal. Words stay with you the rest of your life.” As I listened to Renee talk about her stepfather, I was filled with sadness. It was also difficult for me knowing this interview was forcing Renee to recall such an agonizing time in her life. Although she knew she could stop if her experiences were too painful to discuss, Renee continued through her tears.

Lindsay, recalling a similar experience involving the suffering of abuse, explained:

I was sexually molested by the neighbor boys before the summer of going into third grade, and I don't know, I feel like that contributed to my diagnosis... I knew [this experience] was there, but I didn't have feelings or emotions about it until I got older and learned more of what had happened and realized that when I reached out that no one was there to help me. I told this neighbor's brother, who I thought was my best friend- he was older; I idolized him - I was in love with him, I thought he was the coolest guy in the world and he did absolutely nothing. He didn't say anything, he didn't do anything, and I never told anyone again until I

was 21. I guess that was my little brain saying, “If you reach out, it doesn’t really matter.”

Lindsay, discovering at a young age that she no longer wanted to be herself, began exhibiting peculiar behaviors such as cutting off her eyelashes in order to look different. “I didn’t want to be me anymore, I read a lot of books, and so I wanted to be Hiawatha, because then I didn’t have to be me.” It brought tears to my eyes to think of a little girl alone in her pain with a pair of scissors, drastically cutting off her own eyelashes to escape her reality so she could be someone else. These feelings of wanting to escape are supported in studies about bipolar disorder and childhood abuse (Garno et al., 2004).

Christine was also abused as a child:

I had a very rough childhood. When I was growing up we were abused, physically abused, emotionally abused, in a significant way, by my stepdad and my mother. There were several times that during school I’d be pulled out of class and my body would be inspected for bruises and belt marks... we moved a lot - I went to a bunch of different elementary schools because we would move back and forth from my grandma’s back to home because of the abuse.

Although the abuse continued after Christine’s mother and stepfather divorced, it was less severe and different. She recalled being awakened in the middle of the night by her mother in order to clean all the toys. Like Renee’s experiences growing up, Christine was expected to be perfect. Her escape was her job, school activities, or anything that took her away from home. Once again, as I listened to another story about childhood abuse, I was horrified that Christine had also endured this physical and emotional pain as

a young girl. After hearing these women tearfully tell me time and time again how they were abused as children, there were times when I would return home after an interview and literally collapse in the arms of a loved one and sob.

Chloe also grew up in what she described as a violent home. She suffered physical and mental abuse from her father and regularly witnessed her father physically abuse her mother. “I was always told by my father ‘you’ll never amount to anything.’ Everything had to be perfect - it wasn’t acceptable to be anything but.” Chloe’s escape was school, where she was an extremely high achieving student. However, she eventually turned to drugs and alcohol as a way to self-medicate from the pain she endured as a child. There is a strong connection between bipolar disorder and substance abuse, resulting in many individuals diagnosed with bipolar disorder and comorbid substance use disorder (Ward, 2011). Even without formal dual-diagnoses, most people with bipolar disorder use and abuse drugs and/or alcohol (Swann, Dougherty, Pazzaglia, Pham, & Moeller, 2004). While it is unclear why this co-occurrence exists, some research speculates that substance abuse is a symptom of bipolar disorder, substance abuse is a way to self-medicate bipolar symptoms, substance abuse causes bipolar disorder, or that bipolar disorder and substance use disorder have common risk factors (Bizzarri et al., 2007).

Onset of Bipolar Disorder Experiences

People with bipolar disorder often realize through self reflection that there was a defining moment that set them apart from others. Since it takes approximately twenty years to formally diagnose bipolar disorder at the average age of 40 (Ghaemi et al., 1999), that would put the initial onset of symptoms occurring approximately in the late

teens to early twenties. All six participants recalled a time in the past, prior to formal diagnosis of bipolar disorder, when they knew something wasn't right. The common theme that emerged from these interviews was the hormonal changes occurring in the participants. Meg's onset occurred when she was 13 years old:

Yeah, there was, I mean there was a definitive night, I remember waking up and feeling like my body felt really different, like something was wrong or there was just really weird. And I went up to my parents' bedroom and I just said "I think I'm going to die because I just feel so weird," and I don't actually remember what they said, which is interesting now that I think about it. But the next few months was just a time of trying to figure out what was going on for me and my parents and, I mean I think my siblings were just kind of watching and hoping that it would settle down but... it was just like there was chemicals that were washing through me, or like there had been, like a lightning storm, or like an electrical charge it just felt like these things like flowing, and yeah... it just felt strange, and then the way it showed up over the next few months I guess, was like my sleep cycle was backwards, like I was sleeping during the day and couldn't sleep at night and so then I would get like, get off, and I missed a lot of school because I was up all night. And it was hard to communicate, like, sometimes I wouldn't be able to express what was going on, verbally.

Meg continued to experience this feeling of chemical imbalance in the years following. She was diagnosed as hypoglycemic after her first onset and began a rigid diet regimen which helped, but she knew there was still something else going on inside her. She was eventually diagnosed with bipolar disorder in her twenties, after other severe

episodes. She now acknowledges the hormonal connection to her onset of bipolar symptoms. As a result, she and her husband made a decision to not have children. Meg seemed nonchalant when she disclosed this personal decision, but it saddened me to realize the difficult choice she and her husband had made.

Lorraine was married after graduating from college with a degree in education and had taught school for one year. “I first knew that I had mental health problems after the birth of our first child, I think I was 23, which was 2 years after we got married.” Her husband was in the air force during the Vietnam War. He was stationed in Hampton, Virginia. Lorraine was educated; she had read all the books and thought she would have no problem being a mom. She told her husband he could go to work. “I don’t remember a lot of what happened, but what I’m told is that I would take our newborn daughter, and we had friends in the same apartment complex- but I would carry my coffee cup with me to go visit, which they thought was strange.” She was hospitalized in a private psychiatric hospital for post-partum psychosis for five months and had fifty-five electric shock treatments. Like Meg, Lorraine’s experience was directly related to a hormonal change. Lorraine could not recall many details of that period in her life because of the high number of electric shock treatments she endured. I grasped the apparent severity of her symptoms when she disclosed she was locked in a hospital room during that time.

I can remember being in lock up... then I can recall some kind of spirit, or God-like figure said, Nancy, I have a purpose for you... this is the part that gets me... and from then on, I got better.

This experience was powerful for Lorraine and emotional for me as I listened with chills up my spine.

Christine recalled encountering mental instability at approximately age 16, when she would “throw fits it the driveway” and flip from being fine one minute to “freaking out” the next minute. Her parents took her to a psychiatrist, who discussed the possibility of a depressive disorder, but she was not put on any medication until five years later, after the birth of her first child. Looking back, she realizes the hormonal connection to her mental instability. Christine tearfully recalled her experience a few years later after having given birth to her twin boys:

Right after my twins were born, I had severe post-partum depression to the point where I was hospitalized, because I had dreams that I would smother my boys... and, you say that out loud and you're automatically a child abuser - and this was the first of many times that DHS became involved... because I said I had visions of me smothering my babies... they make you feel like a monster that you could think something so horrible.

Eventually, the Department of Human Services declared the claims were unfounded. Soon after this experience, Christine lost her job. This began a downward spiral for Christine, “I was incapable of caring for myself and others... and I became incapable of doing anything at that time.” Her self-esteem plummeted. She was hospitalized for major depressive disorder four or five times during the following six years. She had several suicide attempts and began to cut herself and pop pills. Two months after her husband committed suicide, Christine became involved with “a dangerous man.”

The guy was a severe methamphetamine drug addict, and I didn't discover that until I had already let him move in... and I got involved in it, and I made a

complete mess of everything. I lost- somebody in my family brought DHS into it and I have not had custody since.

At Christine's hearing a year later to have her children removed from her custody, she was told she could fight to keep her kids, and she had six months to prove herself. At that point she had already made the choice that she wasn't going to survive. "... this was going to be my last act on this earth and then I was going to kill myself that weekend. I was going to cut ties with everybody... and I was just- I was done." Luckily, that never happened. Christine woke up that day and "grew up." Hearing Christine reveal these excruciating details filled me with sorrow and empathy more than she knew.

Chloe is very intelligent. She was a high-achieving student throughout elementary and junior high school, and was involved in band and choir. At the age of puberty, she felt something change: "when I went to high school, I believe is when everything started- the click started as far as going off in my brain. I started using drugs and alcohol very much. I just wanted to be away from home." Again, this pivotal, hormonal change in a girl's life is when the onset of bipolar symptoms appeared for Chloe.

Lindsay recalled a similar experience during pre-pubescent and pubescent times in her youth:

In fourth grade we moved to a different neighborhood, I would sit up nights - I would just sit on the edge of my bed and look out the window and just bawl and bawl, and bawl and think about death. I had no idea why. I wasn't connecting it to anything- I couldn't understand why I was doing it. I was scared to tell my mom, because she would think I was crazy for thinking about death all the time.

Lindsay started acting out. She began drinking at a very young age. Looking back, she feels she was trying to cope with everything that was going on with the prior sexual abuse. Her mother took her to a psychiatrist when she was 14 and she was diagnosed with depression. “He did put me on medication for a little while, but I quit taking it. I continued bouncing back and forth between depression and mania... I did a lot of drinking and drugs, because I felt crazy, and I didn’t want to feel crazy.” She also went through a promiscuous stage, which is typical of a victim of childhood sexual abuse. Lindsay was sent to an institution for one month at age 15.

Renee also recalled something changing for her around age 14. Prior to that, she was a straight A student. “When I was in 10th grade, I got rebellious. I started doing drugs, skipping school, acting out... my parents sent me to a psych - supposedly the best in town. They put me in [the hospital] locked unit....from May to November.” Although during this time Renee had difficulty in school, she continued actively participating in music and sports. She remembers being happy one minute and then crying the next minute. Life was constantly full of ups and downs. Her first of several suicide attempts occurred at age 15: “I did it wrong. I sliced the wrong way.”

School Involvement and Achievement

All participants were actively involved in school as youngsters, most often in creative activities. These activities included choir, band, art, and sports. This fact supports Jamison’s (1993) theory that individuals with bipolar disorder tend to be creative people. Renee was told all her young life that she was not worth anything, that she would never be anything, and she set out to prove them wrong. “I can remember my stepfather saying, ‘if you’re not going to do something the best, don’t do it at all.’ So I

had to be the best at everything, and of course the best is never enough- to this day.” She recalled:

I was in every musical, every choir, swing choir, band, jazz band... I was in marching band and in my senior year I was a color guard. I used to store my first keyboard (it was a suitcase electric piano) in the music room. Me and my friend Kelly would get passes out of gym and go jam in the music room office while the teacher was teaching choir. I was also in synchronized swimming, and a cheerleader in junior high... Being on stage singing was the best high I've ever had.

Renee went to college in her thirties as a single mom with two school-age boys at home. Her motivation was about being the best. She had to have the best grades and would get very upset if she got a B. Early on, she took a math class and had difficulty, so she dropped the class. She did not ask for help. This changed by the end of her college experience when she took algebra and astronomy. She saw the professors outside of class and asked for help. She did not disclose, however, that she had bipolar disorder, and that feelings of being overwhelmed could push her into a depressive downslide. It took her twelve years to get her associate's degree. She graduated with Phi Theta Kappa honors.

All other participants shared similar experiences in being high achieving students and very goal oriented, being straight A students, involved in numerous scholastic and extracurricular activities. Christine stated:

School was for me was very, very easy. I was a teacher's pet. I was part of the gifted and talented program. I remember thinking that books and learning was

something I was good at and I flourished at, and I got my kudos from my teachers quite a bit. I was accepted very well by my teachers.

Christine was actively involved in various activities during high school, especially in music, in which she received a letter. After she graduated, she attended college and was very successful. She was on the dean's list. Christine became pregnant with her first child during her sophomore year. It took her five years to earn her bachelor's degree with a major in criminal justice and psychology, and a minor in music. She became pregnant with her twin boys right before she graduated, cum laude. After several difficult years of dealing with bipolar disorder, substance abuse, hospitalization, losing custody of her children, suicide attempts, and now fibromyalgia, Christine is currently working toward her master's degree. She is a little scared about succeeding as a graduate student, but stated that now she isn't afraid to ask for help if she needs it.

Lindsay recalled similar experiences to the other participants during elementary school. "In third grade I was a straight A wonder student. When I was in my younger elementary years, my teachers always had to find little busy projects for me because I'd get my stuff done so fast." When she was in junior high, she remembered a very supportive Vice Principal who worked hard to protect and help her. He did not know exactly what was wrong with her, just that something was off. His compassion made a difference in her life and she remembers him to this day.

After some difficulty in high school, Lindsay transferred to an alternative high school, where she did well and received her high school diploma. She then went to a technical school the following fall to become a juvenile correction officer when she was 18 years old. She dropped out after one year, because she had difficulty with the rigid

philosophies she encountered from her instructors and fellow students. She was constantly at odds with them and she felt defeated. After this, a few years later at age 23, Lindsay enrolled at a university and did well for a short time, until “I thought it was cool to party with all the college kids.” She again dropped out of college and began abusing alcohol. After she stopped abusing alcohol a few years later, Lindsay’s bipolar disorder became full blown, because she was “no longer self-medicating with alcohol.” She was hospitalized for a week and put on medication for bipolar disorder. She bounced back and forth mentally between depression and mania for fifteen years and tried to commit suicide ten times. “It didn’t matter if I existed.” Lindsay became involved in a toxic relationship which worsened her feelings of worthlessness. She finally resumed seeing a good doctor and found a pharmaceutical regime that worked, although she still cycled between depression and mania. During this time, Lindsay attempted college again:

I decided to go back to school in my late twenties. It took two years at [a junior college] and I did fairly well. I got excellent grades. I strived really hard to be perfect... I did well and graduated on the dean’s list with an associate’s degree in science.

Upon getting her associate’s degree, Lindsay started back at another university to study psychology. She was still in the toxic relationship at this time, and she felt her life was spinning out of control. She went off her medication and began drinking again. She was rapid-cycling between depression and mania. Lindsay dropped out of the university after one and a half semesters. She did not reveal her bipolar disorder to any college personnel or ask for help.

Chloe was a bright student, who excelled and was very active in band and choir during elementary and junior high school. She recalled a dramatic change when she began high school. Although she continued writing, she discontinued her extracurricular activities. She graduated from an alternative high school and started college. She quickly became overwhelmed and dropped out. She has unsuccessfully attempted college three or four times. Reflecting on this now, she stated, “looking back, if I could have taken just two [classes] at a time.” The feelings of being overwhelmed were too much. She did not seek help from her professors or other university personnel, because of the negative stigma surrounding bipolar disorder. In later years she tried again:

I attempted college again through vocational rehab, but they wanted me to take four classes. They were like, “you’re smart - you can do it,” but unfortunately I took math as a first one, and I’m not good at math at all, I’m more of the creative type... so four classes - it was just too much... I got behind, so I quit. I was very disappointed in myself. I would still like to go back to college... I could have been a very successful person, but this illness stopped that from happening.

Chloe was very sad and reflective about her college attempts. However, these failed attempts pushed her to achieve in a non-traditional educational experience. She attended classes again at the vocational rehabilitation facility and received professional certification in Peer Support. “My own success came out of college failure. So am I really a failure because I didn’t go the traditional route? I don’t feel that I failed. I feel it pushed my creativity into self employment.” I felt happy for Chloe that she focused on her accomplishments and defined her own success.

Meg was actively involved in school. “I really liked having a schedule. And, like I got up the same time every day, and I went to band - that was before school, so I think I would say I found comfort in a routine and having structure.” She continued on right into college after she graduated high school with honors. Meg had thoughts of becoming a doctor or a teacher, so she began her college career with an undeclared major. She took general education courses and did well in them but she soon had feelings of being overwhelmed, possibly due to the lack of a constant routine:

College was much more difficult because my schedule was much more up in the air. I tried to set it, you know, like, well if I go to breakfast at 7:20 in the morning, go practice the French Horn, I still did band for the first two years, then go to Calculus, but I think college was when I started to feel more overwhelmed, and I think to me that has been a close relation to the bipolar - it's the overwhelming, it's a trigger for me. And it did not blow up all the way throughout my whole college experience, like I made it all the way through college without an episode, but I do remember much more feeling overwhelmed, like how can I ever get this History text book read, and how can I write this paper.

There were people along the way who helped Meg push through. She recalled attending a Calculus help group every night during first semester of her freshman year, which helped her get through the class. Second semester she took an English class with her roommate. “It was English Novel and we got almost to the end of the second semester and I was just like, I just can't read anymore, and so she read the book to me... if I get overwhelmed, I get paralyzed and I just stop.” Although she had struggles, she graduated with a double major in English and French. Meg took advantage of study

groups, but she never shared her mental health issues with any professor or academic advisor.

Lorraine was raised by parents who put a great value on education. She was actively involved in “just about everything” in high school and was valedictorian of her graduating senior class. She continued on to college that fall and earned her bachelor’s degree in education four years later. She taught school for one year and then stayed at home to raise her children. When reflecting on her decision to return to graduate school many years later, she recalled:

I probably got overwhelmed at times, but not necessarily because of the classwork... in fact it was exhilarating to me, it was my ticket out. I didn’t really want to live on the farm anymore- I wanted out. I wanted a new life. I wanted to be productive. I wanted the security... I could have easily said, “Oh Lorraine that’s stupid to go to college when you’re 50 years old,”... I mean, when you don’t have any money, and your husband wants to stay here in this rural area- I had all these strikes that weren’t logical, they were reasons why it’d be better if I just did the status quo- but the status quo was not working for me. I was hospitalized all the time. I was just on this treadmill- I had to break this mold somehow and get away and think about what do I want in my life, and like I’ve accomplished something.

Lorraine never felt the need to ask for any help during college. For her, going to school was an escape from the mental instability she had endured throughout her adult life. She received her master’s degree in social work and had a successful career working with the elderly until her retirement two years ago.

Although each participant considered herself a high achiever, post-secondary school experience was not void of challenges, some overwhelming at times. None of the participants ever shared their concerns with or asked for help from professors, educational support staff or any other college personnel regarding their bipolar disorders.

Coping Strategies

The coping strategies were very similar amongst all six participants. The successful strategies included strict adherence to pharmaceutical intervention, exercise, eating healthy foods, getting adequate sleep, and having a strong support system. Renee spoke of calling her sister when she felt depression looming. “Normally, I know when I’m going into a downslide. I’d call her and say, ‘talk me up,’ to keep me from hitting that bottom. I could just call her and cry for no reason. I didn’t even know why.”

Many of the participants spoke of creative outlets, such as writing, music, and cooking. Both Renee and Chloe are writers. Renee just published her first novel and Chloe hopes to one day write her memoirs. Continuing with higher education was also a common coping mechanism in itself, although this at times led to feelings of being overwhelmed which is a bipolar trigger for all the participants. Lorraine found it helpful to be part of a small group of women who attended classes together while working on a master’s degree in social work:

There were four of us adult women, all of us about 50, and we would meet and drive about 100 miles to school, twice a week for four years... and we carpooled, we’d try to get in the same group so we could talk over the lessons. That was a very good experience.

Coping strategies during the navigation of post-secondary school were taking a smaller course load and having a routine. Christine, who is currently pursuing a master's degree, is taking fewer classes per semester than she did as an undergraduate student. While Christine did not disclose her bipolar disorder to university personnel during the pursuit of her bachelor's degree, she is further along in her acceptance of her illness and is open to doing so now if needed. "I'm not afraid of asking for what I need when it comes to my education. I am very skilled at research and resources so I've always been able to at least find the offices that would support me."

All of the participants felt empowered when helping others. Chloe is quite involved with her local NAMI chapter, speaking to people about her bipolar disorder in hopes that it will help others with similar struggles; "it's helped me recover and I know I can help others." Reaching out to others who battle mental illness, by sharing their personal experiences was therapeutic for each participant, and I believe this is what led these strong women to participate in my research study. Other coping strategies were meditation, spirituality and practicing mindfulness and cognitive refocusing. Lorraine beautifully stated:

I'm thinking about how I cope with things now- I just think of it as riding the wave... and I've been through this so many times... and just remember it's always going to get better... so even if you feel like you're sinking, just be easy on yourself. Don't add more stressors to your life. Just be kind, be gentle and ride out that wave and know that eventually you'll be back to yourself again. And also know that this is probably going to happen again- and when it does, just know that you're going to ride out that wave again.

While positive coping mechanisms are the key to managing bipolar disorder, there are also ways people cope that are extremely negative. This includes substance abuse. Four out of six of the participants used alcohol and hard drugs as ways to cope and numb the pain. In reality, this is not coping at all, but rather it is a form of escape; and the ultimate escape, suicide, was attempted many times by the same four participants who struggled with substance abuse. Thankfully, these suicide attempts were unsuccessful.

Conclusion

There were several commonalities in the six women who told me their life stories. The most powerful connection was the finding that bipolar disorder for females is at its worst during hormonal cycles. This finding was strongly prevalent in all six interviewees. Puberty and/or childbirth seemed to be the trigger for the onset of bipolar symptoms for every participant. Another common theme that was very disturbing to me was the finding that the presence of childhood abuse was in four of the participants' pasts; these same participants also turned to substance abuse. Another finding was that low self-esteem and feelings of worthlessness were also factors amongst several participants. It was also found that all the participants were high achievers as youngsters, which according to MacCabe et al. (2010) could be an important link, putting these high-achievers at a four times greater risk for later adult onset bipolar disorder.

Another important finding was the fact that because of social stigma, all participants were reluctant to talk about their bipolar disorder to their college professors or academic advisors when they felt overwhelmed. Granted, being overwhelmed is part of any college student's life, but for a student with bipolar disorder, it can mean the onset of a depressive or manic episode, with dire results. Students with physical disabilities ask

for accommodations frequently. It is expected in our society that these types of accommodations are made; in fact it is commonplace, without judgment. Mental disability is a whole different thing. We, as a society, have a long way to go to remove the social stigma surrounding mental illness.

I am grateful that my research study gave these six women a chance to share their stories. I shared much of myself with them as well, which was reflective and rewarding for me. It was an extremely emotional experience, from listening to the gut-wrenching stories firsthand, to hearing the stories repeatedly as I listened, typed, and analyzed what they had to say. All these women really want is to be accepted and understood by others. This can be a difficult thing when it's hard to accept and understand ourselves.

Chapter 5

Conclusion

Overview

By conducting this qualitative, phenomenological research study, I desired to further understand the lived experiences of six women with bipolar disorder who navigated a post-secondary degree. As an educator, I wished to provide information through my data collection and analysis for other educators, as well as the community at large, to have further awareness of bipolar disorder and possible ways to provide support to individuals afflicted with the illness. Bipolar disorder affects 2.6% of the population over age 18 (Lejeune, 2011) and often presents for the first time during the college years. Seeking to better understand the lived experiences of individuals with bipolar disorder could help educational practitioners intervene and assist post-secondary school students who are struggling. The phenomenological interviews in my study provided an in-depth look at six women with bipolar disorder and their respective trials and tribulations throughout their lives, educationally and otherwise.

Reflection

I was deeply affected by the experience of hearing very personal stories from the participants in my research study. I could easily relate the emergent themes in these stories to my own life experiences as an educator and mental health consumer. Of particular interest to me was the link between high-achievement at a young age to later adult onset bipolar disorder. As an educator, it is important to realize that certainly not all high-achieving students are bipolar. These young over-achievers, rather, have a disposition that puts them at four times greater risk for bipolar disorder later in life. How can educators delineate which of those students are the at-risk? It is impossible to identify

these individuals at an early age by their high achievement alone. This association is only realized later in life through retrospective personal reflection. I clearly see this connection in my own life; however, does this connection serve any purpose other than simply acknowledging the connection? Probably not. The important key for educators is to be aware that individuals with bipolar disorder could be amongst the many students enrolled in their classes. Accommodations for students with physical disabilities are regularly included on course syllabi. Inclusion of possible accommodations for students with mental disabilities on a syllabus would be one simple way to reach out to students with bipolar disorder. This would at least assure such a student that the instructor has mental health awareness and is open to considering possible intervention if the student is struggling due to bipolar disorder.

As an educator, I am keenly aware that each student who walks through my classroom door comes to my class with a unique set of life circumstances. While I cannot possibly know each student's history, I can take the approach of looking at the whole person with empathy and understanding. The stories from the six women made me realize that living with difficult experiences such as childhood abuse, substance abuse, poor family relationships, and mental illness would make learning more complicated. As an educator, I want to teach the whole student. Obviously I want them to learn in content specific areas, but even more, I want them to learn life lessons, self discovery, the value of lifelong learning, and where they fit in the world. As I listened to my participants' difficult recollections, it triggered a memory of my student teaching practicum in elementary music at a tough Los Angeles public school many years ago. The students had been preparing for a concert that night. One student in particular was absent from the

concert, which would severely affect his grade. I could not understand how this student could miss such an important event. The next day I learned there had been a drive-by shooting that had directly impacted this student; a family member had been killed. From that day I have always remembered that every student has a story or journey.

College is demanding. Feelings of being overwhelmed are routine for nearly everyone; this is the norm. Most students “step up” and work hard until the paper is written, the book is read, or the project is finished. Or they don’t. Instructors often assume that if a student does not complete the class assignments or performs poorly on an exam it is due to lack of preparation. While this is sometimes true, educators must realize that there may be another reason. It is my goal to effectively teach my students. If a student fails, I have failed as a teacher. Being aware of why a student might be struggling is my responsibility. The answer lies in me creating a classroom climate that meets the needs of all students, even if those needs are unknown to me. If I view the whole person then I can offer a safe place to learn and approach my students with empathy and compassion so they feel they can talk to me about any difficulties they might have. We cannot “see” bipolar disorder. However, as effective teachers we can be aware of mental illness and offer a caring learning environment in which a student feels comfortable asking for help or accommodations, without feeling the negative stigma or judgment that surrounds mental illness.

Literature Review and Findings

Coping Strategies. I reviewed many research studies which describe important coping strategies for individuals with bipolar disorder such as pharmaceutical intervention, getting enough sleep, eating a balanced diet, behavior therapy, cognitive

reshaping, having a creative outlet, and having a strong support system (Jamison, 1993; McManamy, 2006; Michalak et al., 2006; Murray et al., 2011). All six participants described experiences aligned with the research regarding the aforementioned coping mechanisms, especially having an adequate amount of sleep. This important coping strategy is supported by the reviewed literature that individuals with bipolar disorder have abnormally shifted circadian systems (Harvey, 2008). Another very important component to successfully coping with bipolar disorder is feeling a sense of connection to others (Murray et al., 2011). While these studies examined coping strategies for individuals with bipolar disorder in the general population, I wanted to study individuals with post-secondary school experience because of the link between intelligence, school-achievement, creativity, and high academic grades, especially in subjects such as art, music, and creative writing (Goodwin & Jamison, 1990; MacCabe et al., 2010).

Since post-secondary school is a time when at-risk behavior, such as substance abuse, lack of sleep, and overwhelming pressure to meet deadlines is prevalent (Lejeune, 2011), I wished to further understand how college students with bipolar disorder successfully coped when the aforementioned possible at-risk behaviors of college students could be triggers for mania and/or depression. The findings in my study were aligned with the reviewed literature research studies on bipolar disorder coping strategies for bipolar individuals in general; however there are few studies that delineate coping strategies for college students with bipolar disorder. Federman (2011) suggested that college students with bipolar disorder receive help and support within the university campus in counseling centers as opposed to counseling centers outside the university. This would result in the student feeling a sense of connection (Federman, 2011) which

supports the notion that connection to others is a successful coping strategy for individuals with bipolar disorder (Murray et al., 2011). While none of the participants sought help for their bipolar disorder from any university personnel during their post-secondary school experiences, Lorraine found the connection to other female students helpful as she completed her master's degree.

School Involvement and Achievement. The research that young high-achieving students are four times greater at risk for later adult-onset bipolar disorder (MacCabe et al., 2010) is compelling. All of the participants in my study were high-achievers as youngsters, especially in the arts. This finding is supported by literature which links creativity to bipolar disorder (Goodwin & Jamison, 1990; MacCabe et al., 2010). All six women also had a history of low self-esteem which is supported in the literature that abnormal self-esteem is present in bipolar disorder (Knowles et al., 2007). The finding that the participants were perfectionists, which literature suggests is also a common element found in individuals with bipolar disorder (Knowles et al., 2007) is equally convincing. The links between high-achievement, perfectionism, and low self-esteem could provide insight into why young over-achievers are at-risk for later adult-onset bipolar onset.

The findings in my research indicated that college students with bipolar disorder are reluctant to talk about their illnesses with university professors or personnel. While Federman's (2011) research gives useful suggestions for helping college students with bipolar disorder, if most students are not willing to disclose their illnesses, it is difficult to provide intervention. Perhaps the answer to this dilemma lies in educating the educational

community on mental health awareness. This could create a climate of acceptance so that students with bipolar disorder feel safe to disclose their illnesses.

Onset of Bipolar Experiences. The common link in the onset of bipolar symptoms in my research study was the finding that the female hormone cycle was a major trigger in the first bipolar experiences in all of the participants. This finding is aligned with DiFlorio and Jones' (2010) research on bipolar disorder and gender. Four of the participants experienced bipolar symptoms during early to late adolescence and two participants experienced severe bipolar symptoms after childbirth and were hospitalized for postpartum psychoses. The fact that women are over 23 times more likely to be hospitalized during the first postpartum month (DiFlorio & Jones) is alarming.

Another commonality among the participants was a history of substance abuse. The existence of bipolar disorder and comorbid substance use disorder is common (Swann et al., 2004; Ward 2011), although the connection is unclear. Some research suggests that substance abuse is symptomatic of bipolar disorder, abusing substances is a way to self-medicate during a bipolar episode, substance abuse can cause bipolar disorder, or that bipolar disorder and substance use disorder share common risk factors (Bizzarri et al., 2007).

Home and Family Life. The most disturbing finding regarding home and family life was that childhood abuse was a precursor to the onset of bipolar disorder. Severe physical, emotional, or sexual childhood abuse is present in approximately half of adults with bipolar disorder (Garno et al., 2004). The connection between childhood abuse and bipolar disorder is also associated with suicide attempt and substance abuse (Garno et al., 2004). Four of the six participants experienced childhood abuse. The same four

participants each attempted suicide multiple times and each abused alcohol and drugs. The two participants with no history of childhood abuse also had no history of suicide attempt or substance abuse.

Recommendations

The insight I gained on bipolar disorder through conducting the six phenomenological interviews in my research study allowed me the opportunity to reflect upon recommendations for intervention when college students afflicted with bipolar disorder struggle during the pursuit of their degrees. First, educating university professors and other university staff on bipolar disorder would lead to greater mental illness awareness in general, help to identify at-risk students, and lead to intervention if needed.

Renee stated:

You know, they talk about, especially in this day and age with all the shootings... they talk about recognizing mental health issues before something bad happens. There are signs – but until it's retrospect, you don't really see the person until they're ready to snap... but I think that educators on all levels, from kindergarten through Ph.D. should have at least one class on mental health issues.

Next, I agree with Federman (2011) that on-campus counseling centers would be most beneficial to students. The mere presence of these counseling centers could also help generate a greater awareness of mental illness within the entire college community.

The known link between childhood abuse and bipolar disorder (Garno et al., 2004; Hyun et al., 2000) is an important theme that needs to be further explored. This was an unexpected theme that emerged from the interviews, one that was difficult to hear. The fact that half of all adults with bipolar disorder suffered abuse as children is

disturbing. With further examination of this phenomenon, perhaps we could more fully understand the implications and recommend earlier intervention for individuals with bipolar disorder and their families.

Another interesting phenomenon is that high achievement during elementary through high school can lead to later adult onset bipolar disorder (MacCabe et al., 2010). The fact that individuals with excellent school performance and high academic grades are four times at greater risk for later bipolar disorder than individuals with average school performance and average academic grades is worthy of further examination. This phenomenon, along with perfectionism was present in all the stories I heard from the participants in my study. I also recommend that elementary and middle school teachers and administrators pay close attention to high-achieving students who also show signs of low self-esteem and feelings of not being good enough. This practice could help identify individuals who are at-risk for later onset adult bipolar disorder.

Another very common theme in the interviews was the link between bipolar disorder and the female hormone cycle (DiFlorio & Jones, 2010). I recommend further examination of this link in order to provide support to women, especially after childbirth. This hormonal trigger was extremely traumatic for Christine after the birth of her twins, as she had horrifying thoughts of harming her babies, and although she tried to talk about her disturbing thoughts with a counselor, she felt she was treated as a “monster.” If Christine’s forthcomings of her morbid thoughts had been met with a compassionate understanding of the link between childbirth and bipolar disorder, the extreme fear and sheer terror Christine felt could have possibly been alleviated or at least lessened.

Similarly, the hormonal trigger Meg experienced at age 13 during her first onset of bipolar symptoms was so powerful that as an adult, she decided to not have children.

Implications For Future Study

My research study had limitations. I sought to tell the stories of six women with bipolar disorder who navigated a post-secondary degree. There are a variety of lived experiences of individuals with this disorder, and I interviewed a small sample of this population. There are strong similarities in the lived experiences between these six women, and the themes that emerged from the data I collected from these participants are compelling. These themes coupled with the supporting literature on the strong links between bipolar disorder, childhood abuse, and school achievement are worthy of my recommendations for further investigation, awareness, and understanding for a larger population of individuals with bipolar disorder. The women in my study were greatly affected by hormonal cycles during puberty and childbirth. Future research on bipolar disorder and multiple stages of female hormone cycles including puberty, childbirth, as well as menopause would be beneficial.

Other implications for future study could include training of school personnel; particularly educators who work with gifted and talented students. Gifted students are often high-achievers and are therefore more likely to develop later adult onset bipolar disorder. Educating and training teachers of these students could help identify students who are high-achieving, but show signs of perfectionism and low self-esteem.

Final Thoughts

The six strong and brave women who shared their personal accounts of living with bipolar disorder greatly affected me as an educator, researcher, and mental health

consumer. Their collective willingness to share their experiences for the sake of helping others was both powerful and empowering. I was deeply moved by the honest and painful truths shared by these women. As I listened, I was filled with anguish at times and hope at other times. Mostly I was filled with empathy, because I understood. I reflected on my own personal struggles with mood shifts and low self-esteem during my school experiences. Merriam (2002) explains that qualitative researchers are changed by the research experience. I was definitely changed by the experience of hearing these women's stories by embracing my own vulnerabilities. I truly connected and identified with these women. I am proud of their collective courage to speak from the heart and tell their stories. In her book, *The Gifts of Imperfection: Let Go of Who You Think You're Supposed to Be and Embrace Who You Are*, vulnerability researcher Brené Brown (2010) tells us to either walk inside our stories and own them or "stand outside your story and hustle for your worthiness" (p. 23). Meg, Christine, Renee, Lorraine, Chloe, and Lindsay own their stories and continue in their recoveries to know self-worth.

This qualitative research journey combining education and mental health has been extremely rewarding. The self-reflection and examination of bipolar disorder as a researcher have been the richest part of this experience. Many people with bipolar disorder lead productive, successful lives. Ongoing research in this field, along with the much needed and deserved support from family, friends, and the medical and educational communities, is essential in helping those with bipolar disorder find balance, happiness, and successful coping strategies during post-secondary school and throughout life. I am inspired and grateful to be a part of this process.

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APPENDIX A

Informed Consent Document

Title of Study: Understanding the Lives of Bipolar Women with Post-Secondary School Experience

Investigator: Lori Heyob Ancona, Doctoral student at Drake University

Dear _____,

You are invited to participate in a research study. The purpose of this study is to examine adults with bipolar disorder who have navigated through post-secondary school, in order to gain understanding of their lived experiences and coping strategies. You are being invited to participate in this study because you have a clinically diagnosed mood disorder. If you agree to participate, you will be asked to participate in three in-person interviews. Interview questions will be centered around your experience in living with bipolar disorder and your coping skills in managing your mood disorder. Each interview will be approximately one hour in length and take place over a period of one month.

The types of questions asked will be:

- Would you please describe your childhood?
- How would you describe living with bipolar disorder?
- How would you describe your school experiences from elementary, middle school, high school and post-secondary education?
- What kinds of experiences, such as support or lack of support for your mood disorder, occurred in the school setting?
- What have been your coping strategies in your management of this illness?
- What are some of your possible triggers for a manic or depressive episode?
- Are there any pharmaceutical interventions as part of your bipolar management?
- Are there any creative outlets that help you manage this disorder?

RISKS

While participating in this study you may experience the following risks:

- Potential of revisiting memories that could create emotional distress
- Could reveal regrets of past experiences
- Possible expression of emotions such as sadness and frustration

If needed, the following counseling support resources are available:

Iowa Concern Hotline (800) 447-1985

Polk County Mental Health Response Team (515) 954-0409

BENEFITS

If you decide to participate in this study there may be no direct benefit to you. It is hoped that the information gained in this study will benefit society by helping to provide understanding of life with a mood disorder and to identify coping strategies for successful management of living with a mood disorder.

COSTS AND COMPENSATION

You will not have any costs from participating in this study. You will be compensated with a \$10 gift card for each interview. Gift card(s) will be given to you after the completion of each interview. You will need to complete a form to receive payment. Please know that payments may be subject to tax withholding requirements, which vary depending upon whether you are a legal resident of the U.S. or another country. If required, taxes will be withheld from the payment you receive.

If you decide to not continue your participation in the study, you will keep your gift cards for each interview, or part of interview that is completed.

PARTICIPANT RIGHTS

Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty or loss of benefits to which you are otherwise entitled. You can skip any questions that you do not wish to answer.

CONFIDENTIALITY

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies, auditing departments of Drake University, and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information.

To ensure confidentiality to the extent permitted by law, the following measures will be taken:

- Data will be transcribed verbatim and stored on password protected computer.
- Data will be coded by creating categories according to theme.
- Data will be stored for three years after dissertation completion and then destroyed.
- Raw data will be accessible to the researcher only, and dissertation committee members only after pseudonym is chosen by you (the participant).
- If the results are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this study.

- For further information about the study contact:
 1. Researcher, Lori Heyob Ancona, at 515-321-5046 or lori.ancona@drake.edu
 2. Researcher's supervising faculty member, Dr. Sally Beisser, at [515-271-4850](tel:515-271-4850) or sally.beisser@drake.edu
- If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, (515) 271-3472, IRB@drake.edu, Drake University, Des Moines, Iowa 50311.

PARTICIPANT SIGNATURE

Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document, and that your questions have been satisfactorily answered. You will

receive a copy of the written informed consent prior to your participation in the study.

Participant's Name (printed) _____

(Participant's Signature)

(Date)

APPENDIX B

Interview Protocol

Interview #1 Protocol

We will begin the first interview with a conversation to introduce ourselves to each other. The interviewees' pseudonyms will be used during the interviews.

**Focus: What is it like to be an adult clinically diagnosed with bipolar disorder?
What were experiences growing up as well as life in the school setting?**

- I. Introduction
 - A. Introduce myself and thank participants
 - B. State purpose for this research and series of 3 interviews
 - C. Share a little about myself
- II. Please tell me about your life growing up.
 - A. Tell me about yourself.
 - B. Describe your experiences growing up.
 - C. Describe your school experiences from elementary to higher education
- III. How would you describe the experience of living with a mood disorder?
 - A. Describe your experiences of first receiving your BD diagnosis.
 - B. What kinds of experiences, such as support or lack of support for your mood disorder, occurred in the school setting?
 - C. What is your experience regarding social stigma and bipolar disorder?
- IV. Thank you. Present gift card

Interview #2

Protocol

Focus: What are the coping mechanisms for an adult clinically diagnosed with bipolar disorder?

The interviewees' pseudonyms will be used during the interviews.

- I. Coping strategies in your management of this illness
 - A. Describe your daily routine.
 - B. Are there any physical things you do routinely to cope with your bipolar disorder?
 - C. Are there any specific mental or emotional things you do routinely to manage your bipolar disorder?
 - D. Are there any specific things you avoid to manage your bipolar disorder?
 - E. Are there triggers that you recognize prior to a manic or depressive episode? Please explain.
 - F. Are you taking prescription medication as part of bipolar management? To what extent does help with your coping strategies?
- II. Support from others important in managing your bipolar disorder
 - A. Describe any support your family provides.
 - B. Describe any support your friends provide.
 - C. Describe any support from school personnel such as teachers or counselors.
 - D. Describe any additional support you feel from others in your life.
- IV. Thank you. Present gift card

Interview #3

Protocol

The interviewees' pseudonyms will be used during the interview.

Focus: Is there a connection between creativity and management of bipolar for an adult clinically diagnosed with bipolar disorder? In what ways could the school setting provide opportunity for coping, creativity, or support for individuals with mood disorders?

- I. Creative outlets that help you manage this disorder
 - A. Do you consider yourself to be a creative person?
 - B. What are some ways you are creative?

- II. Does being creative help you manage your bipolar disorder?
 - A. In what ways do creative endeavors help you manage your bipolar disorder?
 - B. Is there anything else regarding creativity you would like to talk about?\
- III. Support from the school setting
- IV. Thank you for participation. Share how results are available (member check). Present gift card